# Kansas Department for Aging and Disability Services

## Targeted Case Management Study Recommendations Report

June 2024

PUBLIC CONSULTING GROUP

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# EXECUTIVE SUMMARY

The Kansas Department for Aging and Disability Services (KDADS) contracted with Public Consulting Group LLC (PCG) in 2023 to help bring Kansas' intellectual and developmental disabilities I/DD targeted case management system into compliance with the federal HCBS Final Settings Rule.

## OVERVIEW

The Final Settings Rule introduced new requirements for changing the way in which individuals received and experienced HCBS. While most requirements allowed states multiple years to achieve compliance, one requirement went into effect immediately. Effective March 17, 2014, 42 CFR 441.301(c)(1)(6) requires the separation of case management from provision of direct services for home and community based services (HCBS) waivers. The principle of this rule states that a "provider of HCBS for the individual must not provide case management or develop the person-centered service plan." The rule does allow for an exception in situations when there is no other willing or qualified provider. However, the Centers for Medicare and Medicaid Services (CMS) must approve this exception and states must develop risk mitigation practices.

PCG reviewed KDADS' current statutes, regulations, waiver(s), and policies regarding targeted case management requirements and entities. In addition, PCG reviewed deidentified claims data for one fiscal year, to identify individuals receiving targeted case management and direct services from the same agency. The project team also identified peer states for research, to learn how they are addressing or already have addressed the federal requirements for conflict of interest. To further support this study, PCG interviewed KDADS staff and individuals receiving services as well as conducted focus groups, administered a survey, and facilitated regular stakeholder meetings. PCG's study also included the facilitation of a two-day visioning session with KDADS leadership and staff.

Information obtained from the study's activities informed the options and considerations contained in this report. PCG met with KDADS regularly for the data collection activities and summaries of our findings.

## APPROACH

PCG identified strategies that could be implemented to help the I/DD targeted case management system come into compliance with federal HCBS waiver regulations.
PCG's approach to the Targeted Case Management Study consisted of multiple research and data collection methods. Which included:

- Analysis of KDADS claims data and information relevant to this project
- Survey development, distribution, and analysis
- Conduct focus group
- Conduct interviews with KDADS staff
- Conduct interviews with individuals and families
- Develop process maps
- Environmental scan
- Peer state research

- Bi-monthly stakeholder meetings
- Visioning session

PCG sought to research ways to improve system structures regarding billing and current workflow between targeted case management agencies, Managed Care Organizations (MCOs), and the Community Developmental Disability Organizations (CDDOs). As part of this task, PCG performed an analysis of claims data and other existing information relevant to the project to better understand the utilization of community provider services and targeted case management services across the state.

PCG also complied information about how the system structures in Kansas distribute and implement services at each level to create process specific maps. These process maps help to clearly lay out how all systems work together and supported the analysis of potential improvements and identified administrative redundancies.

PCG conducted an environmental scan and interviewed peer states that had already come into compliance with the final rule to identify best practices and lessons learned for Kansas to implement when undergoing transition to compliance. Early on in the project PCG also conducted interviews with identified KDADS leadership and subject matter experts to understand their vision for conflict free case management along with their concerns. In addition, PCG conducted a two-day, in-person visioning session with the KDADS and KDHE staff to determine goals and priorities for the future of targeted case management in Kansas.

With a focus on engaging with stakeholders, PCG sought feedback through online open response evaluation forms, surveys, and a public email. Additionally, virtual bi-monthly meetings were held to update five separate stakeholder groups and collect feedback and concerns throughout the course of the project. Similarly, five one-time focus groups were held for representatives of each of the stakeholder groups to discuss the project more in depth. Finally, PCG conducted several interviews with individuals, family members, and guardians to learn about their experience with the targeted case management system and their opinions about coming into compliance.

Outlined in the report below, PCG developed recommendations that would support KDADS with coming into compliance with conflict-free case management, reduce complex administrative systems, and allow for a more streamlined approach to service delivery to benefit people with disabilities.

## SUMMARY OF FINDINGS

### Data of Kansans Receiving Services

From claims data analysis, PCG identified approximately 37% of individuals were receiving targeted case management and at least one waiver service from the same agency, which is a conflict of interest per 42 CFR 441.301(c)(1)(6). With the current system in Kansas, the state is at risk of losing approximately 50% of its funding for the waiver, should they not come into compliance. Additionally, Kansas will not be able to obtain approval from CMS for the legislatively required new CSW until they are in compliance with the conflict of interest requirements.

### Process Mapping

Outcomes from the PCG process mapping created a series of high-level flowcharts for each entity - targeted case management entities/individuals, MCOs, and the CDDOs - using the information provided during the virtual business process mapping meetings. The collaboration between entities faces challenges related to roles, assessment duplication, timelines, and billing.

**Stakeholder and KDADS Staff Engagement**

PCG analyzed the information obtained from the written and oral stakeholder engagement. Throughout the various types of engagement the following notable themes emerged: there is a desire for standardized training from the state, a need for consistency in contracts and quality assurance measures, and an interest in improving coordination between entities to reduce the level of effort required of individuals and families. Individuals, families, and guardians expressed overall positive experiences with their targeted case managers but would like more support from the state to learn about available resources to expand their choice options.

**Peer State Research**

Seven states were selected based on criteria that would allow comparable transition processes. Interview questions focused on the impetus for becoming conflict free, duration of the transition, rural exceptions, and lessons learned. Some states chose to seek a rural exception from CMS though not all states chose to use the rural exception process. Transition times to conflict free varied from 1-2 years to nine years with 2 states still in progress.

## OPTIONS FOR COMPLIANCE

The data provides valuable information for KDADS to determine compliance options and plan the transition process. PCG identified four compliance options for KDADS to consider. The chosen option will significantly impact future actions, resource allocation, and adaptability to regulatory changes. It's essential to recognize that any option selected will disrupt individuals, families, and the overall system, with some options being more disruptive than others. Below, we outline the roles and responsibilities associated with each option:

**Compliance Option 1: TCM Function Distribution**

Targeted case management becomes the responsibility of CDDOs, targeted case management-only agencies, and independent targeted case managers. They perform the four targeted case management functions of: assessment, support plan development, referral, and monitoring. Direct services are provided by Community Supports Providers (CSPs) only. CDDOs would act as the primary contact, one stop access point for people seeking services, similar to their current operations.

**Compliance Option 2: Targeted Case Management Function Centralization**

Targeted case management becomes the responsibility of targeted case management-only agencies and independent targeted case managers. CDDOs would still serve as the one stop access point but would not perform the four targeted case management functions services. CDDOs would be responsible for eligibility assessments and ensuring those services are being provided to the person. Direct services would be provided by CDDOs and CSPs.

**Compliance Option 3: Shared Targeted Case Management and Direct Services**

Targeted case management and direct services can be performed by all agencies but not for the same individual. This option most closely aligns with the current structure, minimizing disruption and provider loss. The implementation of robust firewalls and mitigation strategies is essential in preventing any conflicts of interest. State staff oversight would need to be increased to monitor the separation of services and comply with federal regulations.

**Compliance Option 4: MCOs Provide Targeted Case Management Services**

Targeted case management becomes a function of the Managed Care Organizations only. They perform the four targeted case management functions of: assessment, service plan development, referral, and monitoring. MCOs could contract out to independent case managers and targeted case management only agencies to meet the targeted case management functions. This option could enhance service coverage but may decrease experienced targeted case management providers. It would also require amendments to state MCO contracts.

Note: This option was not presented to stakeholders because KDADS determined it would not be a viable option prior to stakeholder meetings.

## CONSIDERATIONS

In addition to the options for compliance, PCG outlines additional considerations that KDADS should consider to improve quality and the experience of individuals. These considerations aim to enhance the system for individuals with I/DD.

**Recommendations:**

- **Affiliation Agreements:** Standardize CDDO affiliation agreements to reduce administrative burden, facilitate equitable service provision, and enhance collaboration between CDDOs and CSPs.
- **Duplication of Roles and Responsibilities:** Develop a clear delineation of roles to support a more efficient service delivery. The current KDADS document outlines roles but needs updating to reflect current practices and reduce redundancies.
- **Statute, Regulation, and Policy Updates:** KDADS should evaluate existing statutes, regulations, and policies to identify necessary updates needed to come into compliance.
- **Collaboration with CMS:** Engage in high-level discussions with CMS before formal submission to streamline the approval process and set the stage of approval of the new CSW waiver.
- **Statewide Training:** Implement a comprehensive statewide training plan and equip MCOs, CDDOs, targeted case managers, and CSPs with standardized training to ensure consistent and streamlined services.
- **Billing for Targeted Case Management Improvement:** Targeted case managers expressed concerns about targeted case management billing. With a state outlined comprehensive document outlining requirements and billing services, targeted case managers could reduce their administrative burden and enhance service quality.

# INTRODUCTION

## ACRONYMS AND GLOSSARY

The following terms are used throughout this document. The full meaning of each of these commonly used acronyms is provided in Table 1: Acronyms and Description below for ease of reference to readers.

**TABLE 1: ACRONYMS AND DESCRIPTION**

| Acronym | Description |
|---|---|
| **BASIS** | Basic Assessment and Services Information System |
| **CC** | Care Coordinator |
| **CDDO** | Community Developmental Disability Organization |
| **CFCM** | Conflict-Free Case Management |
| **CMS** | Centers for Medicare & Medicaid Services |
| **CSP** | Community Supports Provider, agencies approved to provide the services defined in the waiver |
| **HCBS** | Home and Community Based Services |
| **I/DD** | Intellectual and Developmental Disability(ies) |
| **KanCare** | Kansas' Medicaid program |
| **KDADS** | Kansas Department for Aging and Disability Services |
| **KDHE** | Kansas Department of Health and Environment |
| **MCO** | Managed Care Organization |
| **PCG** | Public Consulting Group LLC |
| **PCSP** | Person-Centered Service Plan (MCO) or Person-Centered Support Plan (targeted case manager) |
| **QA** | Quality assurance |
| **Title XIX of the Social Security Act** | Federal Medicaid program |

## PROJECT BACKGROUND AND OVERVIEW

The Kansas Department for Aging and Disability Services (KDADS) operates multiple Home and Community Based Services (HCBS) waivers, including the KS HCBS Intellectual and Developmental Disabilities Waiver (HCBS-I/DD). There are approximately 9,020 individuals receiving services from the HCBS-I/DD waiver. I/DD services provided to individuals via the waiver include:

- Assistive Services
- Adult Day Supports
- Financial Management Services
- Medical Alert-rental
- Overnight Respite
- Personal Care Services
- Residential Supports for Adults
- Residential Supports for Children
- Enhanced Care Services
- Specialized Medical Care
- Supported Employment
- Supportive Home Care
- Wellness Monitoring

As the single state Medicaid agency, the Kansas Department of Health and Environment (KDHE) administers and oversees all Medicaid programs, including direct involvement or review of all functions related to HCBS waivers. Through an interagency agreement, KDHE works in collaboration with KDADS to develop and implement program policies, comply with required Medicaid program reporting and auditing, and oversee the licensing of agencies supporting individuals with I/DD.

In addition to KDHE, individuals with I/DD interact with multiple agencies as part of their journey to accessing and receiving services. Below in Table 2, we provide an overview of each agency and their role in supporting individuals with I/DD.

**TABLE 2: KS AGENCIES SUPPORTING INDIVIDUALS WITH I/DD**

| Agency | Role in Supporting Individuals with I/DD |
|---|---|
| **Community Developmental Disability Organizations** | KDADS contracts with Community Developmental Disability Organizations (CDDOs) to serve as the single point of entry for individuals seeking services for I/DD. There are twenty-seven designated CDDOs across the state that are tasked with completing the Basic Assessment and Services Information System (BASIS) that is used to determine an individual's eligibility for HCBS waiver services. The CDDOs also provide quality assurance for any I/DD Community Service Providers (CSP) in their catchment area, or area served by the CDDOs. This ensures that all services are person-centered and that agencies are adhering to all applicable state and federal licensing and service provision statutes and regulations. |
| **Targeted Case Managers (Individuals and Agencies)** | In Kansas, individuals with I/DD are immediately eligible for targeted case management services if they qualify for Medicaid and receive KanCare. Targeted case management services are provided by targeted case managers who may be affiliated with an agency (typically an MCO) or operate independently. The goal of providing eligible individuals with these services and supports is to prevent an individual from institutionalization, ensure continuity of care, and promote maximum independence and integration into the community. Targeted case management services are designed to help individuals gain access to medical, social, educational and other needed services that increase their ability to live their preferred lifestyle. |
| **Managed Care Organizations** | Since 2014 the state of Kansas has contracted with Managed Care Organizations (MCOs) to coordinate care for individuals receiving Medicaid waiver services. The MCOs create a Person-Centered Service Plan (PCSP) to help determine the amount and type of waiver services an individual needs to live in the least restrictive environment, and increase individual independence, productivity, socialization and community integration. Each waiver recipient can choose one of the three contracted MCOs. Once chosen, the MCO assigns a care coordinator to each individual. |
| **Community Supports Providers (CSP)** | Community service provider means an agency or organization who provides services to meet the needs of persons with I/DD related to work, living in the community, and individualized supports and services. |

| | |
|---|---|
| **Self-Advocate Coalition of Kansas (SACK)** | SACK is a statewide advocacy group made up of adults with I/DD, the majority of whom receive services through the Kansas Developmental Disabilities Service System. SACK encourages and teaches people to speak up for themselves and to obtain the highest possible level of independence. |

On March 17, 2014, the HCBS Final Settings Rule went into effect. This rule contained many new requirements for changing the way in which individuals received and experienced HCBS. For many of these requirements, states were given multiple years to achieve compliance. However, one requirement went into effect immediately, as of March 17,2014:

> 42 CFR 441.301(c)(1)(6) states: *Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. In these cases, the State must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by Centers for Medicare & Medicaid Services (CMS). Individuals must be provided with a clear and accessible alternative dispute resolution process*

To meet the requirements described above, service plan development must be separate from service provision for the same individual. In other words, an organization, including all its employees and subcontractors, cannot provide both direct services and case management services to the same individual except in unique circumstances as set forth in HCBS waiver service regulations and guidelines. It is important to note the “the only willing and qualified entity to provide case management and/or develop person- centered service plans in a geographic area also provides HCBS” or also known as the rural exception is one that KDADS has and continues to consider.

Individuals with I/DD are immediately eligible for targeted case management if they receive KanCare and qualify for Title XIX. In Kansas, those who provide targeted case management are responsible for the following activities:

- Assessment
- Service Plan Development
- Referral
- Monitoring

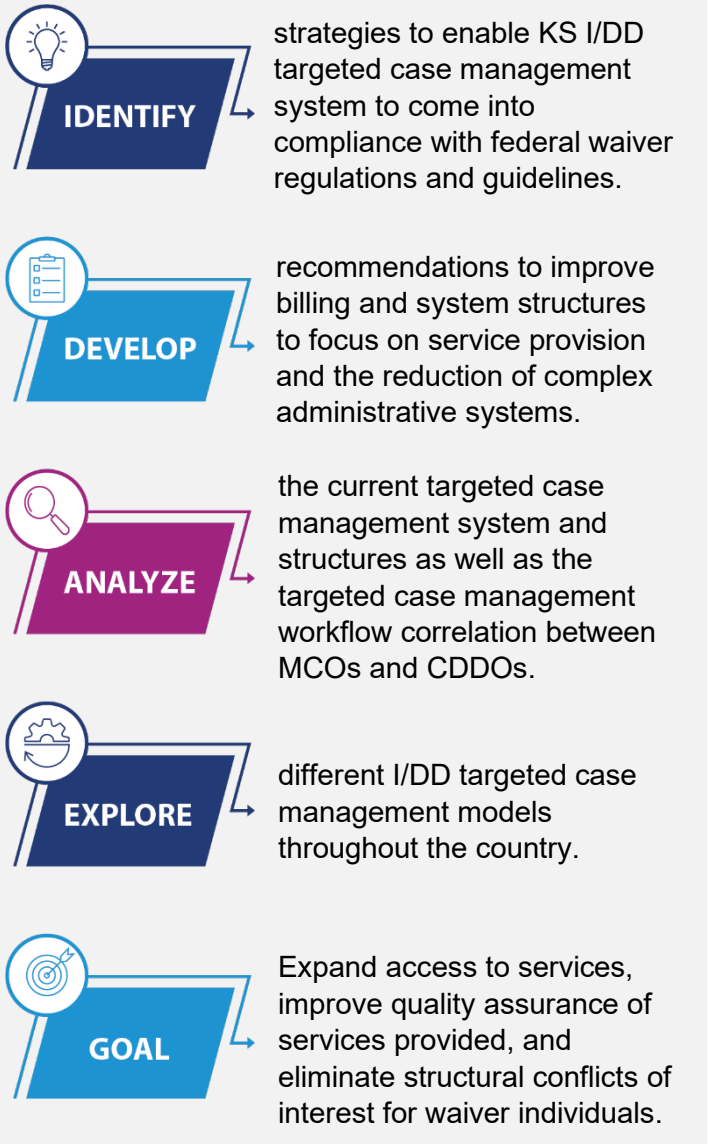
From claims data analysis, PCG identified approximately 37% of individuals were receiving targeted case management and at least one waiver service from the same agency, which is a conflict of interest per 42 CFR 441.301(c)(1)(6). With the current system in Kansas, the state is at risk of losing approximately 50% of its funding for the waiver, should they not come into compliance. Additionally, Kansas will not be able to obtain approval from the Centers for Medicare and Medicaid Services (CMS) for the legislatively required new Community Supports Waiver until they are in compliance with the conflict of interest requirements.

In 2023 KDADS contracted with Public Consulting Group LLC (PCG) to identify strategies that could be implemented to help the I/DD targeted case management system come into compliance with federal HCBS waiver regulations.

PCG was tasked with analyzing Kansas' current targeted case management system and structure along with the workflow between the targeted case managers, Managed Care Organizations (MCOs), and the Community Developmental Disability Organizations (CDDOs) in order to develop and recommend service models that would make Kansas conflict-free per federal statute as seen in Figure 1.

PCG also explored different I/DD targeted case management models throughout the country to provide options that will help Kansas streamline services and enhance service provision to those receiving I/DD targeted case management services. Finally, PCG developed recommendations to improve billing and system structures so that those providing targeted case management could focus on service provision and reduce the complex administrative systems that interfere with the intent of targeted case management services.

**FIGURE 1: PCG SCOPE OF SERVICES**



# TARGETED CASE MANAGEMENT STUDY

To meet the requirements set forth by the Kansas Department for Aging and Disability Services (KDADS), Public Consulting Group LLC (PCG) conducted both qualitative and quantitative data gathering and analysis activities. Below in Table 3 is an overview of the activities with detailed descriptions following:

**TABLE 3: OVERVIEW OF DATA GATHERING ACTIVITIES**

| Activity | Audience | Reason or Goal |
|---|---|---|
| **KDADS Data Analysis** | • N/A | • Identify number of individuals receiving targeted case management and services from the same provider<br>• Identify number of services individuals receive from the same entity<br>• Understand the scope of the conflict |
| **Stakeholder Evaluation Form** | • Individuals, families, guardians<br>• Community Developmental Disability Organizations<br>• Targeted Case Managers<br>• HCBS providers<br>• Managed Care Organizations | • Provide anonymous, ongoing opportunity for any stakeholder to provide feedback or ask questions regarding the Targeted Case Management Study |
| **Surveys** | • Individuals, families, guardians<br>• Community Developmental Disability Organizations<br>• Targeted Case Managers<br>• HCBS providers<br>• Managed Care Organizations | • Gather initial feedback and information to understand the current system |
| **Focus Groups** | • Individuals, families, guardians<br>• Community Developmental Disability Organizations<br>• Targeted Case Managers<br>• HCBS providers<br>• Managed Care Organizations | • Gather additional insight from survey responses to better understand survey results and the current system |
| **Peer State Research and interviews** | • N/A | • Gather information on states that have implemented changes to become conflict-free, those that are |

| | | |
|---|---|---|
| | | in the process of mitigating the conflict of interest and some states that did not have a conflict but a similar structure to Kansas |
| **Interviews** | • KDADS subject matter experts and leadership<br>• Individuals, families, and guardians | • Interview subject matter experts and leadership to understand their goals of the project, what's working well in the system, and areas for improvement<br>• Interview with individuals, families, and guardians to understand their experience under the current system structure; identify what is working well and areas for improvement |
| **Process Mapping** | • Community Developmental Disability Organizations<br>• Targeted Case Managers<br>• HCBS providers Managed Care Organizations<br>• Community Support Providers | • Develop process maps |
| **Vision Session** | • KDADS<br>• KDHE | • Assist in understanding the long- and short-term priorities from KDADS to develop options for compliance and additional to considerations. |
| **Bi-Monthly Meetings** | • Individuals, families, guardians<br>• Community Developmental Disability Organizations<br>• Targeted Case Managers<br>• Managed Care Organizations<br>• General group that consisted of those who could not attend their originally schedules meeting and/or providers | • Provide updates to the stakeholder groups on the project<br>• Collect feedback, thoughts, and any concerns regarding potential changes to the state system |

## KDADS DATA

A crucial part of the development of any recommendations is to collect and analyze data from a multitude of sources using a variety of methods. PCG submitted the below data request to KDADS as seen in Figure 2. Provided data is from Fiscal Year 2022 (July 1, 2021 – June 30, 2022).

**FIGURE 2: DATA REQUEST**

**TCM/Individual data**

- Claims data current fiscal year to past 3 fiscal years
- Authorized units vs. units claimed/provided
- Agency name billing for TCM
- Agencies billing for other services authorized
- Individuals zip codes

**Provider Information**

- Provider Name
- Location(s)
- Information on areas served
- What services they're authorized to provide
- What waivers providers are serving

**MCO**

- Number of individualy they're serving
- Number of new individuals per year

**CDDOs**

- Number of individuals they are serving
  - Annual/Reassessment over the last 3 years
  - Breakdown by CDDO and a compliation of all CDDOS
- Number of new individuals per year
  - Number of initial assessments over the last year
  - Breakdown by CDDO and a compliation of all CDDOs

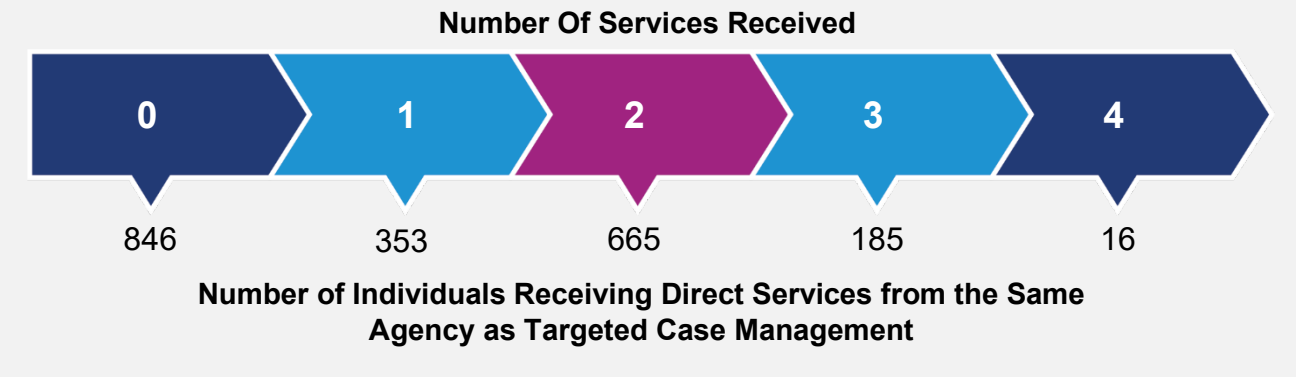
**Individual TCM providers**

- Number of individual they are serving
- Number of new individuals per year

With the data provided from the above request, PCG identified 37% of individuals are currently receiving targeted case management and at least one waiver service from the same agency.

The table below shows the number of services an individual is receiving, in addition to targeted case management, from the same agency.

**FIGURE 3: NUMBER OF DIRECT SERVICES RECEIVED FROM THE SAME AGENCY AS TARGETED CASE MANAGEMENT**




The above data provides information KDADS can use when determining their final option for compliance and the transition process. Decisions should take into account not only the number of individuals and the number of services they are receiving from the same agency, but also the types of services in addition to targeted case management.

Common services that an individual is receiving in addition to targeted case management from the same agency are:

- Habilitative Residential
- Day Habilitation
- Supported Employment
- Wellness Assessment

## STAKEHOLDER EVALUATION FORM

At the beginning of the Targeted Case Management Study PCG developed a Microsoft Form titled Kansas Targeted Case Management Study Evaluation Form. We developed this evaluation form to give stakeholders a way to share with us their thoughts, feedback, concerns, and questions. We structured the form to be anonymous, but also provided stakeholders a way to include their name, agency they are affiliated with, and email address. We placed the evaluation form on the Kansas website for easy access, and we also made it available during stakeholder engagement meetings. Throughout the lifetime of this project PCG received 61 form submissions. Themes identified the form include the following:

- Billing for services outside of targeted case management
- Benefits to “all in-house” services
- Shared personal experiences with targeted case management agencies, MCO, and CDDOs
- Concerns regarding MCOs assuming targeted case management functions

Many of these themes are highlighted in the robust stakeholder engagement conducted for this project. However, one that is not covered is many people’s shared concerns regarding MCOs

taking over targeted case management activities. The proactive measures taken by the project team, such as addressing these concerns during the April bi-monthly meeting, demonstrated a clear understanding of the importance of transparent communication. The assurance provided by both the project team and KDADS that the MCOs assuming targeted case management functions is not being considered was a crucial step in maintaining trust and ensuring that stakeholder concerns are not only heard but also acted upon. Maintaining a level of engagement and open dialog will be key in continuing to foster a collaborative environment where all voices are heard and valued in the decision-making process.

## SURVEYS

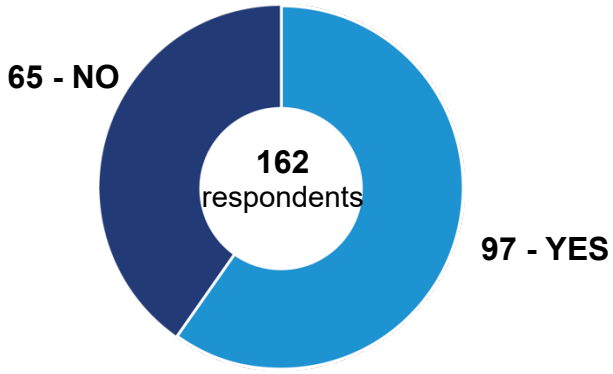
PCG collaborated with KDADS to develop survey questions that were applicable to each audience. Once questions were finalized, they were entered into the Qualtrics platform, the platform used to administer the survey and collect responses. Survey data was analyzed using Microsoft Excel. Below we provide an overview of survey results by audience.

### *Individual, Family, Guardian*

Approximately 192 completed individual, family, and guardian surveys were submitted and analyzed for this report. It is important to note of the 162 respondents who answered if their HCBS waiver services are provided by the same agency (or individual) that completed their support plan and that provides their waiver services, 60% (97 respondents) indicated they were receiving services from the same agency. Though this survey represents only a portion of the population receiving targeted case management, it does highlight the conflict that exists in the current system.

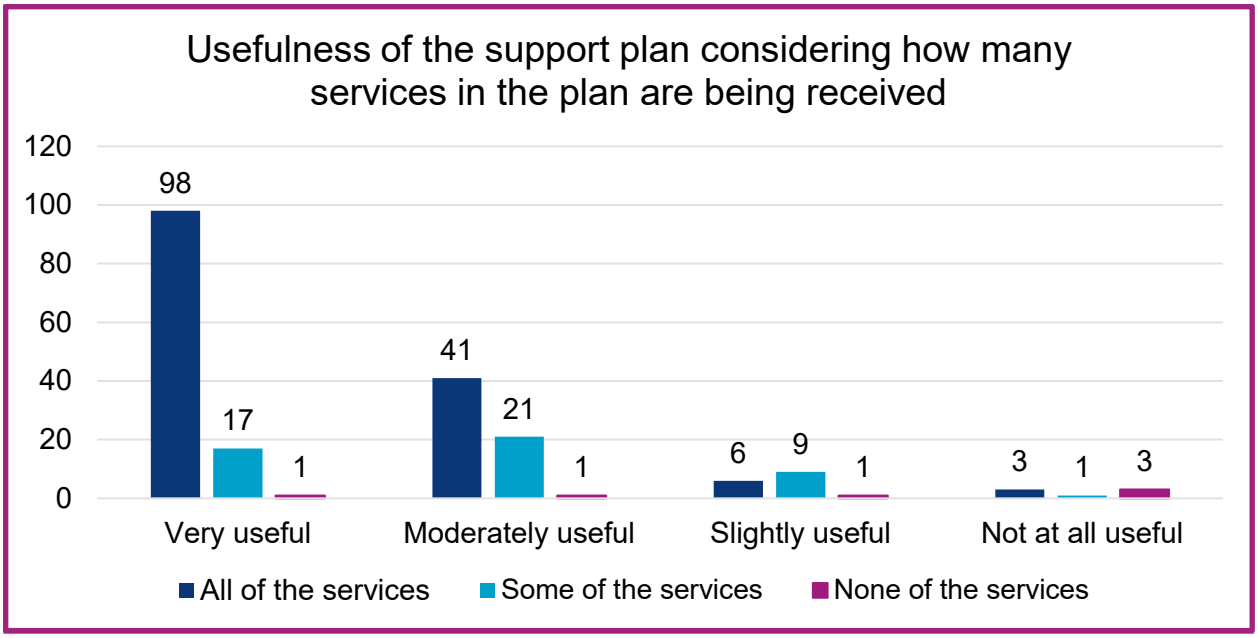
**FIGURE 4: HCBS WAIVER SERVICES AND TARGETED CASE MANAGEMENT PROVIDED BY SAME AGENCY**

Are your HCBS waiver services provided by the same agency (or individual) that completed your support plan and that provides your case management services?




Data from the individual, family, and guardian survey was also analyzed across multiple questions to determine if an association exists between individuals' perceived usefulness of their support plans and how many of the services in their support plans, they are actually receiving. It was found that 66% (98 respondents) who are receiving all of the services in their support plans find their support plans to be very useful compared to 35% (17 respondents) who only receive some of the services and find their support plans to be very useful and 17% (1 respondent) who receive none of the services in their support plan and find their support plan to be very useful. This finding demonstrates a correlation between individuals receiving the services in their support plan and an increased perception of usefulness of the support plan.

**FIGURE 5: SUPPORT PLAN USEFULNESS**




### *Community Developmental Disability Organizations*

The survey was sent to all CDDOs and made available for all CDDO staff. Approximately 89 completed CDDO surveys were submitted, and free response answers were analyzed to identify common themes, which included emphasizing the importance of targeted case management training and clarifying the different roles in the targeted case management system. Respondents indicated a need for targeted case managers to be trained on skills outside of waiver knowledge, such as time management, conflict resolution, and how to facilitate a productive meeting as well as a broad understanding of the system, including community resources and other state resources. Additionally, respondents suggested training targeted case managers on provider quality assurance and how to be better advocates for the individuals they serve.

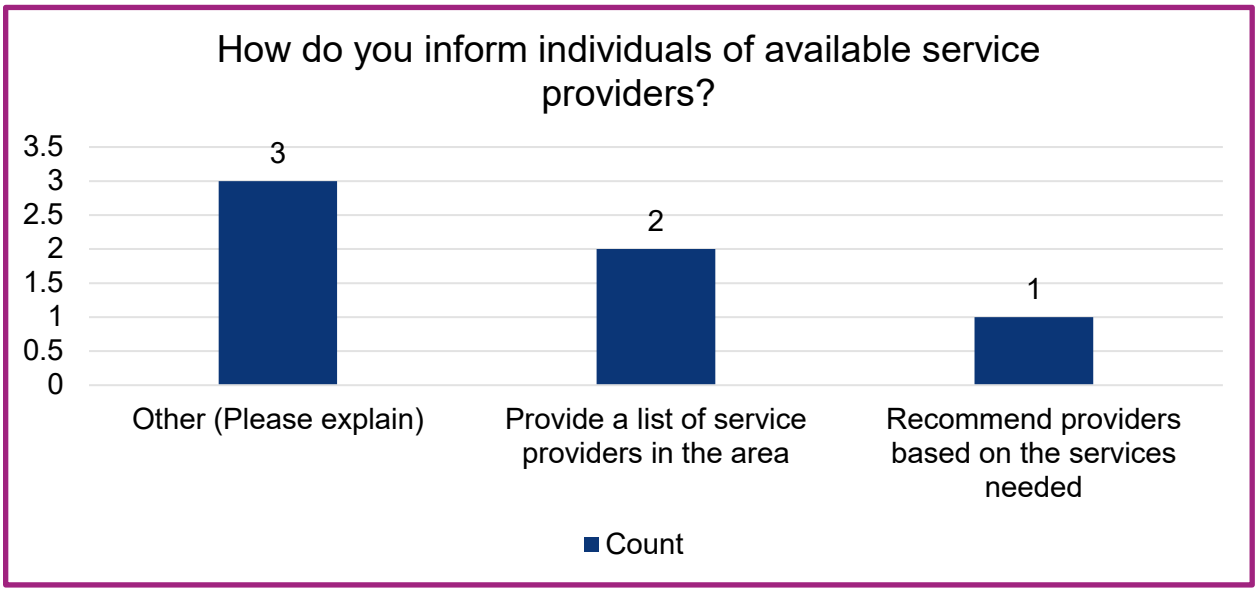
Respondents also suggested additional clarification on the roles of CDDOs, MCOs, and targeted case managers would help improve the flow for individuals accessing services. For example, respondents shared the Person-Centered Service Plan completed by the MCO care coordinators and the Person-Centered Support Plan completed by targeted case managers can be duplicative of each other.

### *Managed Care Organizations*

The MCO survey was shared with each MCO and available for any level of staff to complete. Five completed MCO surveys were submitted and analyzed to identify key findings, such as a better understanding of the working relationships between MCOs and targeted case managers. For example, when asked if they found targeted case managers accessible for coordinating purposes, 100% (5 respondents) indicated no, the targeted case managers were not accessible. In the free response associated with this question, respondents shared the level of accessibility of targeted case managers is dependent on the targeted case manager and agency—some are responsive and available, while others are not cooperative when coordinating.

Additionally, respondents selected the ways in which they inform individuals of available service providers with the most common way being to refer individuals to the CDDOs (75%; 3 respondents selected Other and provided a free response explanation with this answer). This method was followed by providing a list of service providers in the area (50%, 2 respondents) and recommending providers based on the services needed (25%, 1 respondent).

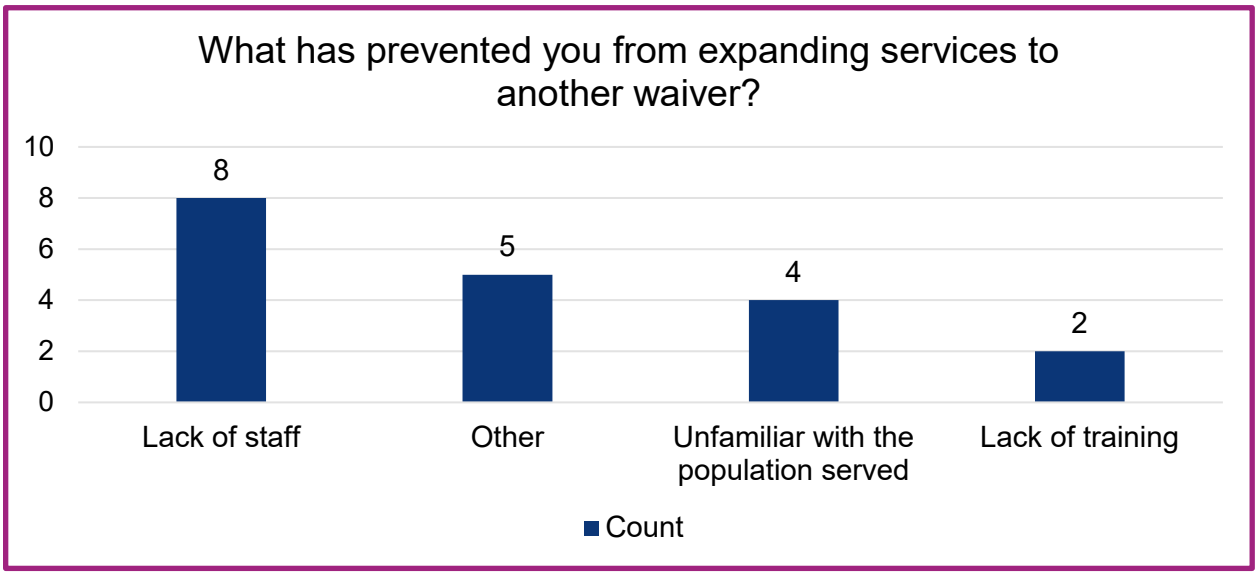
**FIGURE 6: HOW MCOS INFORM INDIVIDUALS OF AVAILABLE SERVICE PROVIDERS**




### *Community Service Providers*

15 completed surveys were submitted for the HCBS service provider survey. All respondents were providers of I/DD waiver services and 47% (7 respondents) indicated they would be open to providing services to other waivers, including the Autism (AU) Waiver, Frail Elderly (FE) Waiver, and Brain Injury (BI) Waiver. When asked what prevents them from expanding into additional waiver services, respondents chose Lack of staff (53%) as the most common reason followed by Other (33%), Unfamiliar with the population served (27%), and Lack of training (13%). Only one respondent who selected Other submitted a free response explaining their choice, which shared they have not expanded services due to the process to become a provider, Final Rule requirements, and challenging relationships with CDDO staff. These findings demonstrate an interest for some providers to expand their services offered, which is promising for increasing provider capacity.

**FIGURE 7: PREVENTED FROM EXPANDING SERVICES**




13 respondents answered if their agency had a waitlist at the time the survey was taken. 46% (6 respondents) indicated their agency did have a waitlist, and of those respondents 67% (4) attributed the waitlist to being unable to recruit and/or retain staff. Respondents who completed a free response for this portion of the survey identified the need for more funding and training opportunities to increase staff and applicant quality.

### *Targeted Case Managers*

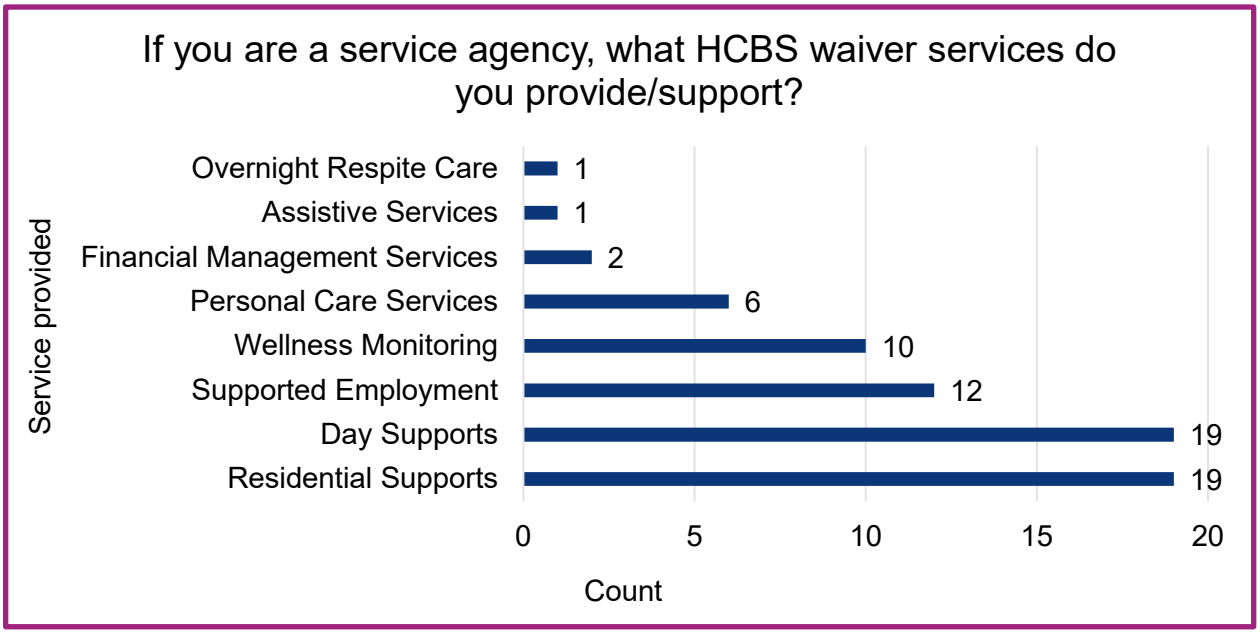
53 completed surveys were submitted by targeted case management respondents who work for a variety of different agency types. 49% (26 respondents) worked for a service agency that provides both direct HCBS waiver services and targeted case management, and of those respondents who worked for a service agency, 83% (19 respondents) provide residential supports and day supports followed by 52% (12 respondents) providing supported employment and 43% (10 respondents) providing wellness services. Though respondents to this survey represent only a portion of the targeted case managers currently in the I/DD system, this statistic is important to note as it demonstrates the type of direct service agencies that may need additional attention and support from KDADS for capacity building during the transition to compliance.

**FIGURE 8: AGENCY TYPE**

Please select what best describes your agency

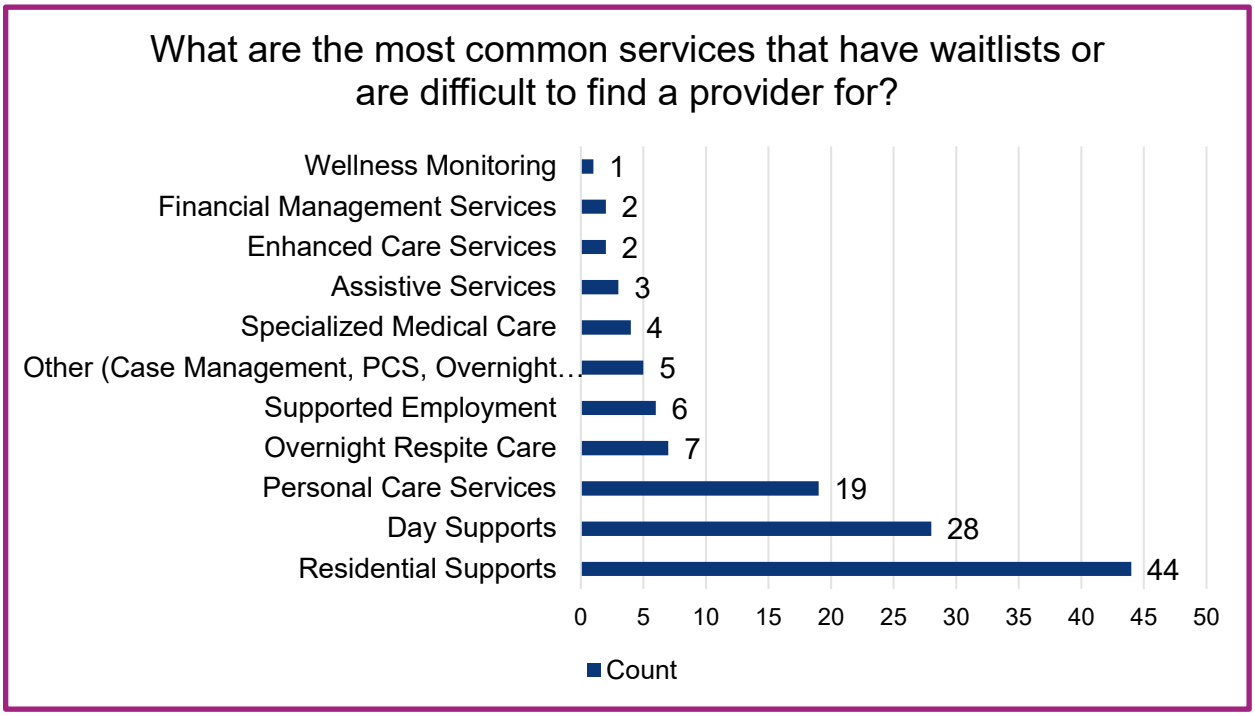
| 26 respondents | 20 respondents | 5 respondents | 2 respondents |
|---|---|---|---|
| **Service agency** (provides direct HCBS waiver services and targeted case management) | **Targeted case management agency** (more than one staff member/employee, does not provide any other services) | **Independent targeted case manager** (no agency, single staff member) | **Other** (Provides oversight to targeted case management services, targeted case management services with HCBS Camps in the summer and during school breaks) |

**FIGURE 9: WHAT SERVICES ARE PROVIDED**




Within the survey, 83% (43 respondents) indicated they work with providers (including their own agencies) who have waitlists for services. Specifically, 88% (44 respondents) chose residential supports as the most common service with a waitlist or that was difficult to find a provider for followed by 56% (28 respondents) selecting day supports and 38% (19 respondents) selecting personal care services. This statistic is also indicative of the types of services KDADS will need to provide additional support to for building provider capacity.

**FIGURE 10: COMMON SERVICES WITH A WAITLIST**




## FOCUS GROUPS

After an initial review of survey data, PCG developed questions to ask focus groups for additional context. A focus group was held for each representative group: CDDOs, MCOs, CSPs, and targeted case management agencies. 10 participants for each group were recruited from the stakeholder bimonthly meeting attendance lists. We also performed outreach to recruit individuals, families, and guardians for a focus group, but did not achieve sufficient participation to hold a formal focus group. Instead, we held an informal focus group for individuals, families, and guardians during their regularly scheduled bimonthly meeting.

Questions related to system/provider capacity, training, coordination, and conflict free case management were asked during each focus group. We identified the following themes for each of the five separate focus groups.

**Notable Takeaways**

- Agencies (MCOs, CDDOs, CSP, and targeted case management agencies) have a desire for standardized training from the state.
- MCOs and CDDOs indicated a need for consistency in contracts and quality assurance measures.
- Agencies (CDDO, MCOs, and targeted case management agencies) are concerned about current conflict of interest practices, stating agencies are not providing individual choice.

- Targeted case management and CSP focus groups highlighted the importance of building provider capacity to address provider staffing shortages and limited providers in certain areas of the state.
- Multiple focus groups expressed interest in improving coordination with MCO care coordinators and targeted case managers to reduce the duplication of meetings and level of effort required of individuals and families.
- Individuals and families reported that community resources would improve information access when choosing HCBS providers for services.

### *Training*

CDDO representatives stated KDADS does not provide standardized training to CDDOs, so each CDDO provides its own training for their staff. For this reason, the training is not standardized across the CDDOs and is also not approved by KDADS. Additionally, some CDDOs offer more training opportunities than others. Participants shared they would like to see standardized, statewide training take place again with virtual options included. They also identified wanting more consistent information from licensing, such as but not limited to, understanding their licensing requirements and the steps they need to take to maintain their licensing.

MCO representatives expressed interest in KDADS ensuring policies and training are updated and made available to all MCOs to improve consistency in practices. Participants also shared they would like training to be offered more frequently.

Targeted case management participants expressed interest in KDADS updating and providing training for targeted case managers. They also shared that it would be helpful for the whole system—Targeted case management, MCOs, and CDDOs—to receive training on the targeted case manager's role and how all the entities should interact with each other in an effort to improve consistency.

HCBS Waiver provider participants also identified there has not been consistent training released by KDADS, especially on conflict of interest, in over 10 years. Some expressed confusion over waiver language differing from what they see in practice. They also indicated they are not required to take person centered thinking training, but some providers offer the opportunity for staff to take person centeredness training both internally and externally. Others shared providers will have touch bases on aspects of person centeredness but have not gone through an entire person-centered planning training. This presents an opportunity for KDADS to offer training around this topic.

### *Consistency in Contracts*

CDDO participants identified an inconsistency in contract language across the MCOs, which can make coordination with each MCO difficult as their practices vary from each other. From the CDDO perspective, participants shared it seems as though MCOs will share different information with the CDDOs and targeted case managers from what they hear from the state, and MCOs will follow regulations inconsistently. Participants also shared language in policy somewhat negates the targeted case manager and implies they do not need to be included in individual meetings, so participants suggested that the state revisit this contract language.

Beyond MCO contract language, participants also shared there is little to no consistency in quality assurance (QA) among the CDDOs, which can make it difficult for CSPs and target case managers who affiliate with multiple CDDOs. This can also pose a challenge for the CDDOs as they attempt to mitigate these differences.

### *Conflict of interest*

There was a consensus among the CDDO representatives that they do not typically inform individuals seeking services that a conflict exists when an individual selects an agency that provides both direct services and targeted case management. Participants shared that they felt the level of conflict is dependent on the individual targeted case manager and how they operate under the umbrella of their provider agency. To address this, participants suggested that new, standardized training focus on the targeted case manager code of conduct.

When asked about the conflict of interest between providers and targeted case management, the MCO participants identified rural nuances as an item for consideration. Specifically, in rural areas, the lack of provider capacity limits an individual's choice, which can make coming into compliance with federal regulation more difficult.

Targeted case management participants indicated that individuals, families, and guardians will occasionally ask for the targeted case manager's input when selecting a provider, which can put the targeted case manager in a difficult position especially if they work under the umbrella of a provider service agency. However, participants also stated some families prefer having both targeted case management and services in-house. They stated this preference should be considered when debating the merits of the different compliance options.

### *Relationship building with Targeted Case Managers*

MCO participants indicated the importance of relationship building with their targeted case management counterparts. For example, a best practice is for care coordinators and targeted case managers to try to attend the same meetings for service and support plans to reduce duplication and the number of meetings for individuals seeking or receiving services. They stated this best practice would be easier to accomplish if care coordinators and targeted case managers had stronger relationships fostering collaboration with one another.

Like the MCO focus group, targeted case management representatives indicated the need for improved collaboration between targeted case managers and care coordinators. For example, scheduling meetings together to compete the support plan and service plan would improve collaboration between the two positions.

Individual, family, and guardian participants expressed that creating the support plan can be time consuming, and parents/guardians will occasionally need to spend time revising the support plan if the targeted case manager does not capture information accurately enough. Similar to the targeted case management and MCO focus groups, participants in this focus group agreed that combining support plan and service plan meetings could reduce duplication.

### *Provider Capacity*

Targeted case management representatives shared they felt as though there was inconsistent and/or limited oversight on how providers choose to provide services to individuals. For instance, some providers will choose certain individuals with lower levels of need or certain conditions as opposed to accepting individuals based on availability and capacity. This practice can make it

difficult for targeted case managers to find services for individuals, especially when there are a limited number of providers.

Additionally, participants indicated that what they consider to be a manageable caseload for targeted case managers varies based on the time and effort required to support each individual. Overall, though, participants agreed that if they didn't have to complete daily tracking and billing tasks, they would be able to accomplish more for the individuals on their caseloads.

Representatives from the HCBS provider focus group shared that providers might be interested in expanding into different counties, but they could be limited in doing so based on their current affiliations with CDDOs. For example, Centers for Independent Living (CILs) are funded to serve specific counties and Financial Management Services (FMS) providers already have the counties they serve determined for them.

### *Resources*

The individuals, families, and guardians who answered focus group questions indicated it would be helpful to have resources available to them to navigate the I/DD system in Kansas, such as updated provider lists and a centralized roster of targeted case managers on a single database. Additionally, participants indicated they would appreciate statewide publications and a community calendar to notify them of upcoming events and new information.

## INTERVIEWS

As part of data collection, PCG conducted interviews with individuals, families, and guardians receiving targeted case management in Kansas along with KDADS staff.

### *Individual, Families, and Guardians*

PCG and KDADS conducted outreach to assess interest from individuals, families, and guardians who receive targeted case management in Kansas in participating in an interview with PCG staff. We used several methods of outreach to recruit participants, including bimonthly meetings, flyers sent via email (along with encouragement to share with others), and KS targeted case management website postings. Gift cards were also offered as an incentive for completing an interview. In total, PCG conducted six virtual interviews with individuals, families, and guardians who received, or are receiving, targeted case management in Kansas. Four participants were receiving targeted case management from the same agency providing their HCBS waiver services at the time of our interview. Below we highlight the themes identified from these interviews.

**Notable Takeaways**

- Participants expressed positive experiences with their targeted case managers.
- Satisfaction was expressed with the participants' current providers.
- Concerns were expressed about losing targeted case management as a service and the potential of not being able to keep their current case manager.

All participants, whether they were receiving targeted case management services from the same agency that provides their HCBS waiver services or not, indicated that they have had positive experiences with their targeted case manager. They reported feeling as though their targeted case manager possesses the right information and skills to meet their needs, and that their

targeted case manager stays up to date on this information in addition to acting as a connector to different organizations that may be of interest to the individuals receiving services.

Participants also shared that for the most part, they are satisfied with their current HCBS providers. Participants were given lists of providers to choose from by their CDDO and/or their targeted case manager helped them find provider options. Some participants mentioned changing providers over the course of their time receiving HCBS to find one that better fit their needs, and at least one participant mentioned the challenge of finding providers with staff in the area in which they live.

Whether or not participants were supportive of the transition to compliance, they all expressed concerns over potentially losing their targeted case manager during the transition to compliance. For example, one participant was concerned that KDADS would eliminate the use of independent targeted case managers, while other participants were worried about losing the stability provided by their longstanding targeted case manager because their targeted case manager works for the same provider agency that provides the participant's HCBS waiver services.

### *KDADS Interviews*

KDADS identified seven staff members for PCG to interview for the targeted case management study. PCG collaborated with KDADS to develop a list of questions to complete interviews with internal subject matter experts and leadership. Questions primarily related to the aspects of the current targeted case management system that work well or present challenges, as well as potential barriers to transitioning to conflict free case management. We identified the following themes.

**Notable Takeaways**

- Independent targeted case manager relationships with HCBS providers may be more challenging compared to in-house targeted case management, which is an opportunity for improvement for the Kansas system with redesign.
- To increase the quality of targeted case management services the state should consider providing training across the state.
- Provider capacity development needs to occur to expand targeted case management and provider networks to ensure no individual is left behind in the transition to compliance.
- Review of the person-centered support plan and service plan to potentially modify to ensure less duplication is occurring between targeted case managers and care coordinators.

Interview participants identified targeted case management relationships as a potential challenge in the current system. For instance, independent targeted case managers might have a more difficult time working with – and getting information from – providers than in-house targeted case managers. Additionally, there is the perception that in-house targeted case managers will steer individuals requesting services toward the service provider who employs them. Regardless of whether the targeted case manager is independent or employed by an MCO, they can potentially steer individuals seeking services toward or away from certain providers.

Interview participants also noted that there are some high-quality targeted case managers working in the current system who care for the individuals they are serving and go above and

beyond the tasks they are allowed to bill. There was an expressed desire to expand this network of quality targeted case managers using education and training, credentialing, oversight, and Quality Assurance.

The desire to increase the network of quality targeted case managers intersects with the current challenge the targeted case management system faces where individuals, families, and guardians do not have enough targeted case management agency and provider choices. Interviewees are concerned that the transition to compliance will exacerbate this issue by leading to a loss of targeted case managers. Acknowledging this concern and identifying ways to mitigate it will be helpful when considering solutions and developing a successful implementation plan.

When asked to identify where duplication of roles occurs between targeted case managers and Managed Care Organization (MCO) care coordinators, participants stated the Person-Centered Support Plan (PCSP) completed by the targeted case manager and the Person-Centered Service Plan (Service Plan) completed by the care coordinator include duplicate information. To complete both plans, the targeted case manager and care coordinator would ideally work together and share information, but this doesn't always happen in practice. Additionally, individuals receiving services can experience redundancy (e.g., providing the same information) when they are asked to participate in both plans' creations, not to mention the time-consuming nature of attending two meetings vs. one.

## PROCESS MAPPING

As part of the targeted case management study, PCG was tasked with understanding and analyzing the workflow that exists between CDDOs, targeted case managers and MCOs. To meet this requirement, PCG organized a series of virtual business process mapping meetings with CDDO, MCO, and targeted case manager representatives to better understand the CDDO/MCO/targeted case manager high-level business processes (including all tasks completed during the life of a case – from the time an individual enters intake through case closure), and where activities intersect between the three entities. During these PCG-facilitated meetings we mapped out the high-level tasks using Visio flowcharting software, highlighting areas of interaction between the CDDOs, MCOs, and targeted case managers. We also performed the following activities:

### FIGURE 11: PROCESS MAPPING ACTIVITIES

**Documented the main tasks and activities common across the CDDOs, MCOs, and targeted case manager verticals:**

- What is really happening (not what is supposed to be happening)
- Purposely avoided a detailed discussion of process outliers that differ from common tasks, activities

**Time permitting, discussed what is currently working well and what is NOT working well:**

- Areas of confusion (impacting work)
- Areas of duplication/work overlaps
- Inefficiencies
- Gaps
- Opportunities for streamlining and improving the process
- Best practices

PCG then created a series of high-level flowcharts (found in Appendix A) for each entity using the information provided to us during the virtual business process mapping meetings. We organized each flowchart series by functional area, including intake/eligibility/assessment, reassessment, ongoing services (monitor/QA/report), and financial. We then analyzed our flowcharts and meeting conversations to highlight the following notable takeaways (findings) organized by entity and summarized below.

### TABLE 4: BUSINESS PROCESS MAPPING FINDINGS

| Entity | Theme | Detailed Finding |
|---|---|---|
| **CDDO** | Collaboration | The CDDO intake and eligibility flow chart indicates that targeted case managers and MCOs aren't involved in the BASIS assessment. But in the 9/18/23 Stakeholder Workgroup, targeted case managers mentioned the difficulty of scheduling the BASIS assessment as a barrier to coordinating with CDDOs.<br>• Should targeted case managers and MCOs be included in this BASIS assessment? What are the standards? It doesn't appear that all parties understand their role. |
| **MCO** | Collaboration | The MCO ongoing services flowchart (MCO_OS2) highlighted duplicative tasks:<br>• The MCO and targeted case manager do discuss who handles what tasks (try to follow defined targeted case management activities), but there are some tasks that both MCOs and targeted case managers can bill to Medicaid.<br>• MCOs would welcome clarifications, clearer guidance on who is responsible for performing what assessment tasks. |

| | | |
|---|---|---|
| | | • MCOs are contracted to perform functional assessment, but both MCOs and targeted case managers must document support/service planning. |
| **MCO** | Collaboration | BASIS and annual assessments contain the same questions. If there is no collaboration, duplicate questions may be asked. |
| **MCO** | Other | MCOs would welcome more well-defined timelines for some targeted case management functions. There is a sense MCOs are held to timelines that targeted case managers are not. MCO participants stated, "[There are] no defined timelines for targeted case managers." |
| **Targeted Case Management** | Trainings | Referrals may be made to targeted case managers by educators that are unfamiliar with the I/DD waiver process. |
| **Targeted Case Management** | Consistency | It is required that CDDOs (and other waiver assessing entities) provide options counseling, but targeted case managers indicate that this is not always the case. |
| **Targeted Case Management** | Consistency | Targeted case managers don't always receive timely notification that an individual is bypassing or coming off waitlist. Sometimes individual gets letter and alerts the targeted case manager before the CDDO. |
| **Targeted Case Management** | Consistency | There is a large variation across targeted case managers as to when intake, eligibility, assessment, *and* planning tasks are performed.<br>• Sometimes tasks are performed before an individual is found eligible for Medicaid and approved for targeted case management services.<br>• There is no guidance/roadmap for what tasks and activities targeted case managers are required to perform, and when they are required to perform them. |
| **Targeted Case Management** | Consistency | Each targeted case manager has different service monitoring and PCSP requirements. Really varies here, there are no state guidelines. |
| **Targeted Case Management** | Financial | Targeted case managements financial and billing concerns include: certain targeted case management services are ineligible for billing; there is some overlap between targeted case management and MCO billing; there is a lack of clear guidance on billing criteria.<br>• Targeted case management receives no payment for CHIP services.<br>• Targeted case managers cannot bill for visits to providers, tours of providers. |

| | | |
|---|---|---|
| | | • Targeted case managers cannot bill for QA of files.<br>• Issue with targeted case management-MCO billing overlap. MCO may claim they are a duplicate service and revised to pay or ask for reimbursement of service.<br>• MCO determines if a service is billable or not. There is *no* clear definition of billing criteria, and what targeted case managers have for guidance is old and expired information. |
| **Targeted Case Management** | Financial | Additional targeted case management financial and billing concerns include:<br>• Per KMAP billing, targeted case management agencies are to only keep 90 days, but submission for billing contract specifies 120 days. One targeted case manager shared, MCOs ask for 14 months of information which can be challenging.<br>• One suggestion offered is to move to per-day billing. For example, residential is billed X amount per day (24 hours) even if the individual only uses the service for one hour. Day service is billed with a maximum of five hours per day billed by the hour.<br>• Would like to see a different form of contact instead of billing in 15-minute increments or include training for a better understanding on how to bill in increments It's stressful for staff to perform the task the client needs and make sure to document it in a way that falls under the four pillars of service, but worded in a way that doesn't appear administrative nor duplication of service. Yet the targeted case manager role is administrative and repetitive as the client is in constant need of revision, applying for new services or renewal of service, ensuring the records are maintained and up to date, etc.<br>• Targeted case managers are not able to bill for travel to/from a client like other CMs from other waivers. |
| **Targeted Case Management** | Other | Sometimes providers write behavioral support plans which can be a conflict - Article 63 doesn't identify a lead coordinator. |
| **Targeted Case Management** | Other | Issue: MCOs are perceived as over reliant on the targeted case manager PCSPs to produce MCO service plans (vs. MCOs contacting the individual themselves). |

PCG's recommendations for compliance with conflict-free case management will likely involve altering the existing CDDO/MCO/targeted case management business processes to some degree. As such, PCG took steps to make sure we thoroughly understood the current business processes of each of these three entities so we could recommend additional business process improvements in addition to the business process changes necessary for KDADS to come into compliance with conflict-free case management.

## PEER STATE RESEARCH

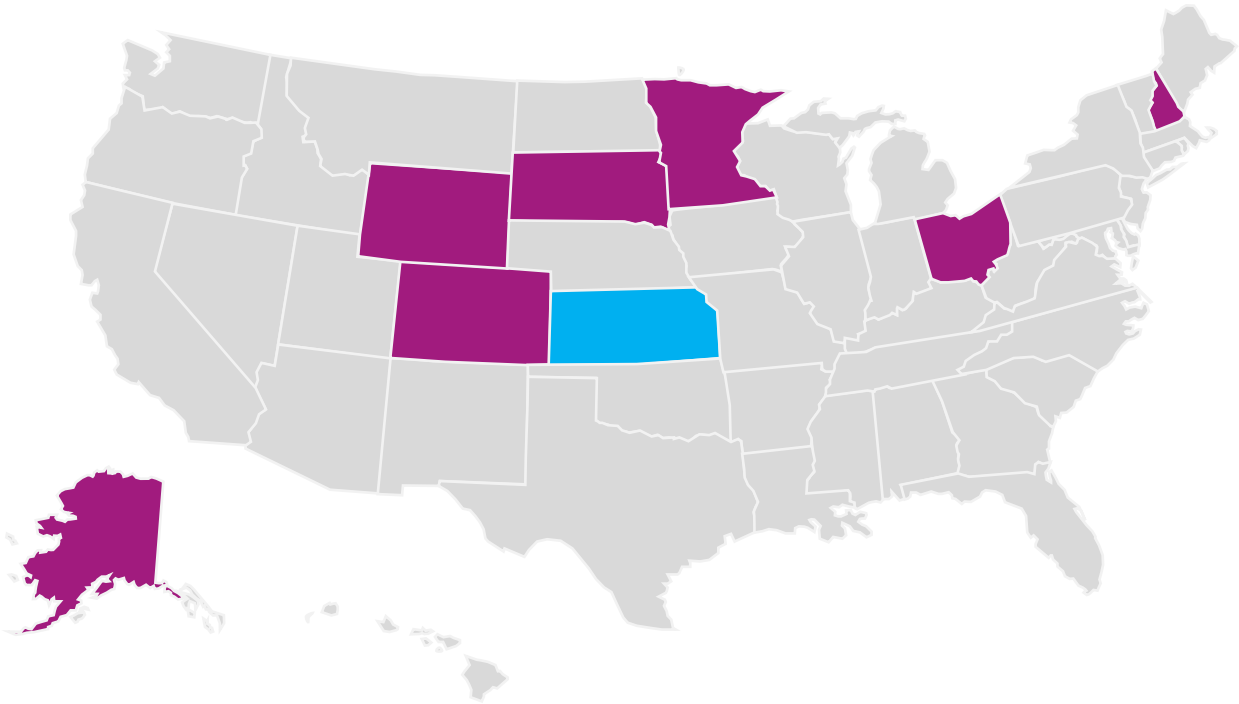
As part of the targeted case management study, PCG was required to research other states and their I/DD case management system and structure. To begin this requirement, PCG conducted an environmental scan to identify seven states for further review and interview. PCG identified these states using the following criteria:

- Have/had conflict between case management and provision of direct services
- I/DD waivers
- Method for reimbursing case management

The seven states PCG chose to interview included Alaska, Colorado, Minnesota, New Hampshire, Ohio, South Dakota, and Wyoming. PCG was able to interview six out of the seven states as Alaska never responded to our interview requests. Interview questions with the states included but were not limited to:

- What was the impetus to becoming conflict free
- How long did it take your state to become conflict free
- Did your state seek a rural exception/only willing and qualified provider exception
- What is working well with the new/what could be improved in the new system
- What lessons learned would you share with other states that are starting this process

### FIGURE 13: MAP OF PEER STATES IDENTIFIED FOR RESEARCH



For each state Table 5 Table 5: State Comparison shows the impetus to become conflict free, length of time it took for the state to become conflict free, rural exception, and additional rural information.

**TABLE 5: STATE COMPARISON**

| State | Impetus to become conflict free | Lenth of time to become conflict free | Rural Exception | Rural exception information |
|---|---|---|---|---|
| **Colorado** | CMS Regulations | Still in progress | X | Rural exceptions are added into their case management agency contracts and regulations. CMS requires the state to keep a close pulse on the provider growth in areas with an exception. Case Management Agencies are required to submit an annual report identifying the conflicted services, how many people are in conflict, and proof that they have been working with other providers to provide services for those individuals. |
| **Minnesota** | MN has always operated with state county administered case management. Service provision was provided by service providers. No conflict existed. | | | |
| **New Hampshire** | Corrective Action Plan (CAP) began in 2017 with a compliance date of 2019 and then pushed out to July 1, 2023 due to COVID. | Six years | X | Providers are required to fill out a form to show they are the only willing and qualified provider and NH had to develop parameters on number of miles and minutes away from the nearest provider to assist in determining if the provider is the only willing and qualified provider. Agencies are exempt for 1 year and |

| | | | | |
|---|---|---|---|---|
| | | | | then there is a re-review process. |
| **Ohio** | CMS Regulations | Nine years, at the time of the interview the state was waiting for CMS review and confirmation of compliance. | | No Rural Exception |
| **South Dakota** | Efforts to remodel their rate structure in 2013. The program had a lot of components, including conflict-free. South Dakota completed through the administrative rules process. | Two to three years and the transition took three to four months. | | No Rural Exception |
| **Wyoming** | House bill passed in 2014 | Two years | X | They have a rural exception in rules and have another waiver that is conflict free and on either waiver the exception has not been used. |

## *Key Findings*

**Identify training methods, processes, and cadence of necessary trainings.** Developing a comprehensive training plan for the state system involved several critical steps to ensure that the workforce is well prepared and the system functions effectively.

**Community communication is critical when making a large system change.** Providing effective communication is crucial when implementing significant changes. It ensures that all stakeholders are aware of the dialog prior, during, and after such a large system restructuring.

**Perform a review of roles and responsibilities.** Establishing clear roles and responsibility for agencies involved in eligibility, case management, service plan and support planning is necessary for streamlining processes and enhancing inter-agency collaboration. Providing clear documentation of the roles can prevent overlap and

confusion, ensuring each agency is aware of their specific duties. States also recommended the use of webinars or other stakeholder forums as an effective way to communicate updates or changes.

**Collaborate with the CMS representative.** States expressed working closely with CMS on the path to compliance, challenges the state is coming up against, and compliance progress.

**Determine an appropriate timeline that works for the State.** Establishing a clear timeline ensures that all parties are aware of their responsibilities and the deadlines that need to be met. Adherence to these timelines not only facilitates compliance but allows providers to effectively plan for future operations, ensuring a structured and reliable path forward.

## VISIONING SESSION

PCG held a two-day in-person visioning session in Kansas from January 30th through 31st 2024 for KDADS leadership and staff members to describe their 10- and 2-year vision for an ideal I/DD system. Participants included PCG staff, KDADS core group participants (those who work on the specific initiative plus key decision-makers), and KDADS larger group participants (other people who "touch" the work of the initiative or do work that will be impacted by the initiative).

### *Visioning Session: 10-Year Vision*

PCG began the visioning session day with a larger group brainstorming exercise that asked participants to describe their 10-year vision for an ideal system with no limits. Core group members were asked to listen intently and create the space for the larger group members to start the brainstorming process. Discussion centered on all thoughts related to the 10-year vision related to:

- Community impact: positive impact on people with disabilities, their families, and their communities
- Services
- System capacity: *what* the state and its vendors/partners are able to do to generate the desired impact ("capabilities") and *how* they're able to do it.

Both groups then discussed and refined the brainstorm to summarize and organize the 10-year, ideal state vision for the system as summarized in the major themes below:

- **Train and educate:** change philosophy on how agencies are driven, how work is performed. Build coalitions to amplify KDADS message, elevate the role of others, and align CDDO incentives towards self-direction.
- **Remove barriers:** strengthen connections, consider a hub connecting all great Kansas resources, perform robust data analysis with common definitions, etc.
- **Become truly person-centered:** improve services, remove silos, achieve true informed choice.
- **Update policies and regulations:** focus on tangible items/activities such as housing, staffing, transportation, access etc.
- **Streamline the system:** give KDADS staff the power and support to simplify a complex system.

- **State as a model employer:** KDADS models best practices, holds others accountable, and bridges gap with behavioral health.
- **Align contracting with philosophy:** build accountability into KDADS contracts.

### *Visioning Session: 2-Year Vision*

Visioning session day two began with a regroup to share insights, reflections, and additional thoughts about day one. PCG then presented data findings, analysis, and observations from our environmental scan, peer state interviews, and peer state comparisons, and discussed whether to refine day one outputs in light of this analysis.

We then facilitated a core group discussion followed by larger group contributions in a mode that mirrored the day one approach. Day two focused on the more immediate time horizon and asked, *"If that's where we want the system to be in 10 years, what does the system need to look like **two years from today** for us to feel confident that we've made a good start toward our ultimate vision?"* The discussion centered on:

- Community impact: positive impact on people with disabilities, their families, and their communities
- Services
- System capacity: *what* the state and its vendors/partners are able to do to generate the desired impact ("capabilities") and *how* they're able to do it.

The groups then discussed and refined the brainstorm to summarize and organize the 2-year, ideal state vision for the system as summarized in the major themes below:

- **Consistent messaging:** make sure goals are being met.
- **Increase opportunities for people with disabilities:** contracting.
- **Increase resources, communications, and connections:** via education and training.
- **Transform KDADS culture:** transparency, communication, collaboration, standardization, application.
- **Work towards becoming more person-centered:** between KDADS and providers. Policy, processes, services, authority, accountability, and action (vs. just talk). Includes relationship building, continuous improvement to free up capacity, and using data that KDADS is already tracking (e.g., National Core Indicators).

### *Visioning Session Takeaways*

Before closing the two-day session, both groups recapped their final major takeaways, thoughts, and considerations from days one and two as summarized in Table 6.

**TABLE 6: SESSION FINAL TAKEAWAYS**

| Topic | Final Takeaway |
|---|---|
| **Staff Support** | • Support case management and direct support professionals to help our vision become reality.<br>• Educate direct line staff.<br>• Recruit people with behavioral knowledge.<br>• Invest in KDADS staff – many key leaders are relatively new. |
| **Final Rule Compliance** | • KDADS controls the KDADS mindset and language on person-centered final rule.<br>• Look to other states as examples to devise a plan for conflict-free compliance that works for KS.<br>• Providers are looking for the decision/timeframe/action on conflict-free. |
| **Operations and Business Processes** | • KDADS needs quality control and consistency.<br>• Lower silos and work to understand the whole business model more broadly.<br>• Do the upfront work on KDADS internal structure, communication, etc. to solve waitlist problem.<br>• Everyone central to KDADS work must be intentional about knowledge management and documenting key work, processes.<br>• How we disburse funds can make a difference.<br>• Research the root cause of issues (in addition to responding to them) to mitigate future reoccurrences. |
| **Communication and Relationship Building** | • Communicate with Kansas Department of Health and Environment.<br>• Prioritize and communicate, including the why.<br>• Think about partnerships with advocacy organizations and providers to generate buy-in, and building relationships with these leaders so they can advocate with their members on KDADS' behalf.<br>• Make sure KDADS is aware of their team/network resources, how they communicate and make connections.<br>• Increase awareness of community resources. |

## BI-MONTHLY STAKEHOLDER MEETINGS

To gather stakeholder feedback at various stages of the targeted case management study and keep them informed of ongoing work, KDADS and PCG held bimonthly stakeholder meetings with individuals, families, and guardians as well as CDDOs, MCOs, and targeted case managers. An additional meeting was held for anyone not able to attend their group's scheduled meeting time and for any interested HCBS providers. Themes from this group are incorporated into the appropriate stakeholder group themes below. The kickoff meetings were held in July 2023 with subsequent meetings held in September 2023, November 2023, and January 2024. Two in-person town halls were held in Kansas in February 2024, so the final bimonthly meetings were held in April 2024. The final bimonthly meetings in April were held to present the options for compliance with stakeholders and gather their feedback. Themes from these meetings as

well as the feedback form that was available to stakeholders to submit after the meetings are included in Appendix H. The following themes were compiled from all meetings for each representative group.

### Individuals, Families, Guardians Notable Takeaways

- Training and resources would assist in navigating the Kansas system.
- County boundaries often limit choice.
- Improvements to consistency statewide would streamline the experience of individuals seeking or receiving services.

Individual, family, and guardian representatives indicated it would be helpful for them to have more resources and education on how to navigate the I/DD system. For instance, they asked for training on how to run their person-centered planning meetings to have better outcomes for their support planning as well as training for self-direction. Additionally, they suggested the CDDOs could be a good source to provide training to parents and guardians. Representatives also identified training on understanding the roles and responsibilities of all agencies within the system and the terminology used as another example for training the state could provide. They indicated a resource guide that explains the system and process of securing and receiving services would be a helpful tool as well. In terms of working with different agencies for services, representatives shared the need for improved scheduling between CDDOs, MCOs, and targeted case managers, which could be aided by a rubric or chart with explanations on what meetings are required and who should be at the meetings.

Representatives also highlighted their concern of county boundaries limiting their choice of providers. Without providers being able and/or willing to expand into new areas, representatives shared their choices were limited unless they wanted to move. This issue is especially prevalent in rural areas of the state. In addition to location limiting choice, representatives also indicated they do not have choice of an assessor or care coordinator when they are assigned at CDDOs and MCOs.

Representatives indicated there is great variation in practices between different regions and agencies. For example, PCSPs are written differently depending on which targeted case manager completes them and how they were trained. Representatives expressed this variation could be due to a lack of consistent statewide processes and/or no statewide training to work towards consistency across regions.

### Community Developmental Disability Organization Notable Takeaways

- Limited provider capacity in certain areas of the state is concerning when transition to compliance needs to occur.
- Identifying roles and responsibilities in the state system to reduce duplication.
- Clear communication and education regarding conflict of interest and the need for transition.

A key theme consistent across all stakeholder groups was the concern with limited provider capacity, especially in certain areas of the state that are more rural and frontier. CDDO representatives indicated the transition to compliance could affect an already limited provider pool

if providers choose to stop providing services instead of coming into compliance. Representatives also identified building provider capacity as a top priority to ensure individuals seeking services will still have choice in providers. Specifically, representatives wanted to know if the state had plans to offer support to targeted case managers who currently work under waiver provider organizations that are in conflict and would be interested in becoming independent. This form of state support could help build targeted case management capacity.

CDDO representatives identified various points of duplication within the current targeted case management system primarily around unclear roles and responsibilities for different agents in the system. For example, representatives shared there is occasionally confusion related to the quality assurance process, and individuals may be unsure of who to contact between the CDDO, MCO, and targeted case manager regarding specific questions. Representatives indicated defining these roles and responsibilities within the system may help with reducing duplication of efforts and improving outcomes for individuals receiving services.

When discussing what some best practices could be to transition to compliance, CDDO representatives identified several options for both provider entities and individuals, families, and guardians. Representatives would like to see training offered before transition occurs to ensure CDDOs, MCOs, and targeted case managers are all on the same page. The group consensus was that a phased approach could be a reasonable way to transition, but there would be a need for administrative support and/or service coordination for day and residential providers, specifically, if it was decided to separate targeted case managers from these provider services.

Regarding communication and education individuals, families, and guardians would need, representatives suggested the state provide a clear message explaining conflict of interest and why the transition needs to occur while emphasizing individuals would not be losing services. Representatives stated it would be helpful to engage individuals in various ways, such as onsite sessions, as well as provide them with a “one-stop-shop” place to ask questions.

### Managed Care Organized Notable Takeaways

- Lack of targeted case manager and/or community service providers could affect those on the waiting list.
- Provider expansion could be limited due to the required affiliation agreement.
- Delineation of clear roles and responsibilities could increase collaboration between MCOs and targeted case managers.
- Providing clear communication of key deadlines, transition meetings, and additional education would benefit the community.

MCO representatives expressed that an early concern with this project was the effect the transition would have on the existing waitlist. Specifically, they were concerned it would increase the waitlist. In addition to an increased waitlist, participants were also concerned the transition would impact the already-limited capacity of the targeted case manager and community service provider networks available to serve individuals. Participants stated that a barrier to expanding these provider networks into larger areas could be the required CDDO affiliation.

Collaboration was a key theme identified throughout the course of stakeholder engagement in this project. To improve collaboration between care coordinators and targeted case managers, MCO representatives suggested the state provide more clarity between the two roles and their

responsibilities in addition to providing standardized training for both roles. They also suggested standardizing language and documentation used across the state to minimize confusion when working with different agencies. Along with this standardization, participants indicated setting expectations for meeting scheduling, document gathering, and timelines for task completion would also improve collaboration between care coordinators and targeted case managers. As a larger goal, participants stated having a shared system for records and scheduling would significantly impact the ability to collaborate.

Though participants were not able to come to a consensus on whether an all-at-once or phased transition approach would be best for the state, they did identify several areas for consideration when informing the public of the transition to compliance. First, dates of key deadlines, such as when to select a new provider, would need to be communicated to individuals, families, and guardians. They would also need to be made aware of any transition meetings that would occur. Sharing this information can be done as a part of education, which the participants identified as a task that could occur in settings such as town halls. It would also need to be identified whether individuals receiving services have natural supports, and if they do not, what the expectation of support from care coordinators and targeted case managers would be.

**Targeted Case Managers Notable Takeaways**

- Delineation of roles and responsibilities for care coordinators and targeted case managers to support efficiency and relationship building.
- Provide examples of non-billable tasks targeted case managers complete.
- Training suggestions for improved quality of targeted case management and the overall system.
- Considerations and preference for transitions to compliance.

Targeted case manager representatives identified the need to improve collaboration not only with MCOs but also with CDDOs. The challenges identified by representatives included not having defined roles between the targeted case management position and the care coordinator position as well as inconsistencies in the methods of operations of the different MCOs. Representatives suggested sharing meetings with MCOs for the same individuals they serve may help foster better relationships with care coordinators. They also suggested that a statewide database for both entities to access information about individuals would aid in the timeliness of sharing information between both agencies/people.

Representatives shared improving coordination with CDDOs would support the system in running more efficiently. Specifically, they suggested timelier responses from CDDOs to questions involving quality assurance issues as well as requesting choice packets and receiving referrals. Representatives also identified coordinating with different CDDOs can be challenging as they do not use consistent forms or processes across the state. Scheduling the BASIS meeting was also identified as a challenge.

Another challenge representatives identified throughout stakeholder meetings was their inability to bill for certain tasks they complete outside of the four targeted case management functions. For example, targeted case managers cannot bill for CHIP services, visits to and tours of providers, and quality assurance of files. They also indicated there are issues with targeted case

management and MCO billing overlap because MCOs can claim they are a duplicate service and revise pay or ask for reimbursement of service. A potential billing factor to consider as well is that MCOs determine if something is billable or not, but representatives stated there is not a clear definition of billing criteria, and what targeted case managers have is outdated information.

When asked what type of trainings would improve the quality of targeted case management and the system overall, representatives suggested the following topics:

- All trainings required by licensing according to article 63
- Up to date targeted case management manual with updated state testing
- Person centered support planning
- Behavioral support plans
- Risk assessment
- Writing Person Centered Service Plans (PCSPs)
- Billables/case notes
- Encounter billing
- Roles and responsibilities (e.g., of targeted case managers and care coordinators)
- Bias training
- Options counseling (for CDDOs)

Targeted case managers shared several considerations for KDADS when transitioning to compliance. First, they highlighted the rural and metro nuances, stating the same approach may not work for both types of areas. Group consensus would be to implement the transition slowly, but doing so by region could be confusing. In order for the rollout to be successful, representatives suggested KDADS needs to coordinate with MCOs closely and have each case management agency develop their own plan for coming into compliance with KDADS oversight. Representatives also expressed interest in KDADS support of people becoming independent targeted case managers.

Additionally, representatives identified several ways to support individuals, families, and guardians with the transition including, allowing sufficient time for them to prepare for this change as well as providing education on why this is happening, their options, and assurance that they will not lose services. They also indicated preparing targeted case managers with talking points for conversations with individuals about the transition may be helpful in dispelling fears and miscommunication. Representatives also suggested having CDDOs host provider fairs again could be a good way to show individuals their provider options.

## SWOT ANALYSIS

Once PCG completed all data gathering and analysis, we conducted two analyses of Strengths, Weaknesses, Opportunities, and Threats (SWOT) of the current targeted case management model and the current workflows between MCOs, CDDOs, and targeted case managers. Our analyses of each are provided below.

### TABLE 7: SWOT ANALYSIS OF CURRENT TARGETED CASE MANAGEMENT MODEL

| Strengths | Weaknesses | Opportunities | Threats |
|---|---|---|---|
| • Robust provider network<br>• Known providers/ agencies<br>• Existing relationships between providers/ agencies | • Lack of role clarity/definition between targeted case managers and MCOs<br>• Lack of standardized/ consistent practices<br>• Lack of standardized training<br>• Lack of consistent billing requirements from KDADS and MCOs | • Provide role clarification and definition<br>• Develop standardized training which will support standardized and consistent practices<br>• Increased quality of experience for individuals, families, guardians | • Loss of federal revenue and potential recovery of funds due to non-compliance with federal regulations<br>• Individuals, their families and guardians are not afforded true informed choice |

### TABLE 8: SWOT ANALYSIS OF WORKFLOW

| Strengths | Weakness |
|---|---|
| • Existing relationships between agencies<br>• Clearer role definition between CDDOs and MCOs/targeted case managers | • Duplicative processes between MCOs and targeted case managers<br>• Lack of role clarity/definition between targeted case managers and MCOs<br>• Lack of coordination between MCOs and targeted case managers<br>• Lack of standardized forms and processes used by each agency, impacting their relationship/interaction with the others<br>• Inconsistent experience for individuals, their families and guardians |

| Opportunities | Threats |
|---|---|
| • Increase quality of experience for individuals, their families, and guardians<br>• Reduce duplication of activities and functions<br>• Provide standardized training | • Loss of providers due to duplicative/ conflicting requirements and policies<br>• Decrease/poor quality of services and experience for individuals, their families and guardians |

# OPTIONS FOR COMPLIANCE

Public Consulting Group LLC (PCG) has identified four options for the Kansas Department for Aging and Disability Services (KDADS) intellectual and developmental disability (I/DD) Targeted Case Management system to come into compliance with federal regulations. Each option was developed by taking into account the data collection and analysis that occurred throughout the targeted case management study. It is important to consider the implications of each as the option selected will influence the specific items that need to be addressed moving forward. The decision-making process should involve a thorough analysis of the potential impact, resources required, and the adaptability of each option to future regulatory changes.

PCG also acknowledges that no matter which option is selected, there will be a disruption to individuals, their families and guardians, and the system as a whole. The options presented have varying degrees of the disruption, which is something KDADS should take into consideration when making a final decision.

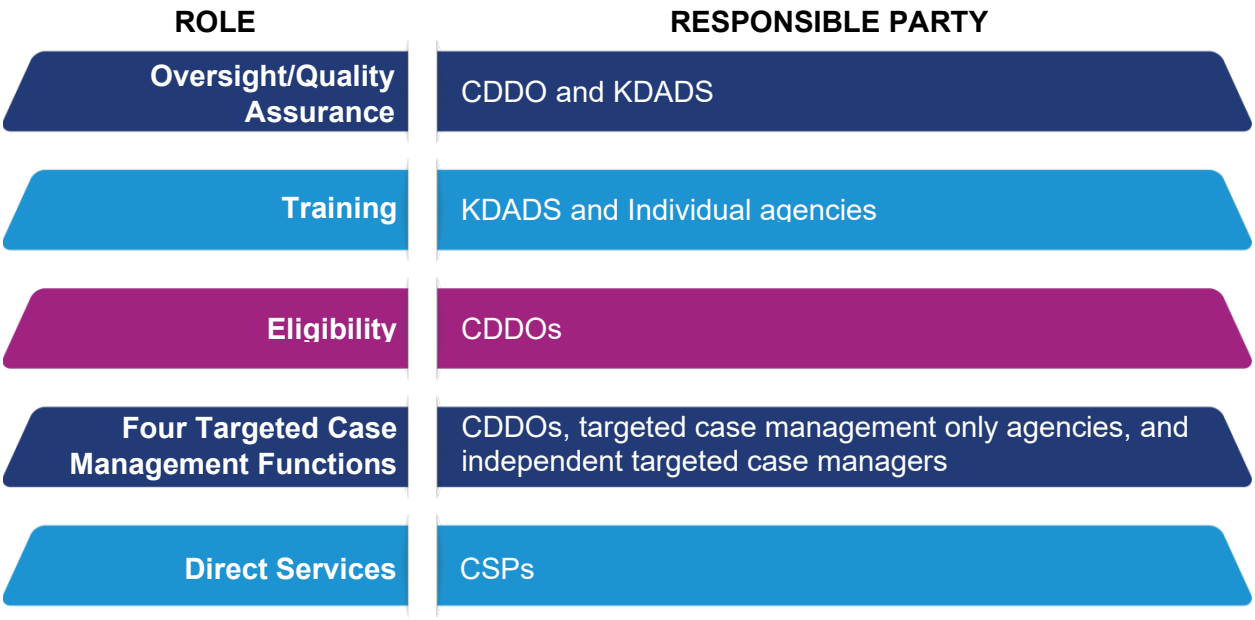
For each of the options we have presented below, we have outlined the following roles and responsibilities assigned to each agency:

- **Oversight/Quality Assurance (QA) –** who is responsible for the review and quality assurance of provider services
- **Training –** who is responsible for the education and skill building for targeted case management entities
- **Eligibility –** who is responsible for determining eligibility for waiver services based on the level of care assessment (non-financial)
- **Four Targeted Case Management Functions –** who is responsible for performing the four targeted case management functions: assessment, service plan development, referral, and monitoring
- **Direct Services –** who is responsible for providing any Home and Community Based Services (HCBS) waiver service (e.g., residential services, day habilitation, etc.)

## COMPLIANCE OPTION 1

Targeted case management becomes the function of Community Developmental Disability Organizations (CDDO), targeted case management only agencies, and independent targeted case managers.

Suggested roles and responsibilities are as follows:




## Advantages

This proposed option offers a structured approach to targeted case management by addressing many key issues identified during stakeholder engagement. Establishing clear roles and responsibilities aims to eliminate the duplication of efforts among the agencies. This clarity not only streamlines processes but also enhances the quality of targeted case management by allowing the agencies to concentrate on case management without the distraction of having to provide direct services.

This option champions individual choice, which is a cornerstone value for many community members. It ensures that individuals have the freedom to select the targeted case manager or agency who will provide targeted case management services and their selection of service providers without the concern of conflict.

Additionally, this option would provide a safety net for those in communities with limited targeted case management providers. In these areas, the CDDO would provide necessary targeted case management services, ensuring that no individual is left without support due to geographic limitations.

This option also supports a No Wrong Door-like structure, which represents a transformative approach to streamlining access to services for individuals with I/DD. In this option the CDDO would serve as the one stop access point (similar to their current operations). CDDOs would act as the primary contact for individuals seeking assistance, ensuring that they receive, at minimum the following:

- Person centered counseling
- Assistance with referral sources
- Eligibility for HCBS waiver programs

The flexibility of the No Wrong Door system allows states to tailor the structure to best suit their unique service delivery models and designs, ensuring that the system is responsive to the specific

needs of their communities. This would not only simplify the process for individuals and families seeking support but also enhances the efficiency of service provision by state agencies.

### Disadvantages

The scale of services provided by the CDDO can dictate the level of effort required for successful divestment. There is also a risk of affecting agency revenues, which could result in attrition of providers. This potential loss of providers could disrupt service continuity and impact the quality or number of providers. KDADS would want to consider a comprehensive plan to weigh the risks and how to mitigate the risks.

### PCG Recommendation:

PCG recommends KDADS implement option one. This option addresses many of the concerns identified throughout the project and would also provide a safety net for those individuals living in an area that may not have independent targeted case managers/targeted case management agencies or a limited number of them serving individuals in the community.

## COMPLIANCE OPTION 2

Targeted case management becomes the function of targeted case management only agencies and independent targeted case managers.

Suggested roles and responsibilities are as follows:

| ROLE | RESPONSIBLE PARTY |
|---|---|
| Oversight/Quality Assurance | CDDO and KDADS |
| Training | KDADS and Individual agencies |
| Eligibility | CDDOs |
| Four Targeted Case Management Functions | Targeted case management only agencies and independent targeted case managers |
| Direct Services | CDDOs and CSPs |

### Advantages

Option two, like option one, offers a structured framework that can lead to enhanced operational efficiency. By delineating clear roles and responsibilities, agencies can focus on their specifically assigned tasks without ambiguity or duplication of effort, leading to a more streamlined workflow. Consistent oversight ensures that standards are maintained and that any issues are quicky identified and addressed. Furthermore, the emphasis on increased quality in targeted case management allows for case managers to focus on the individual receiving services and

addressing their needs and ensuring goals are accomplished. Lastly, having a choice in targeted case management agencies gives the flexibility to select the targeted case manager or agency that best fits the individual's needs.

This option, like option one, also supports a No Wrong Door-like structure, which represents a transformative approach to streamlining access to services for individuals with I/DD. In this option the CDDO would serve as the one stop access point (similar to their current operations). CDDOs would act as the primary contact for individuals seeking assistance, ensuring that they receive, at minimum the following:

- Person centered counseling
- Assistance with referral sources
- Eligibility for HCBS waiver programs

The flexibility of the No Wrong Door system allows states to tailor the structure to best suit their unique service delivery models and designs, ensuring that the system is responsive to the specific needs of their communities. This would not only simplify the process for individuals and families seeking support but also enhances the efficiency of service provision by state agencies.

### Disadvantages

The evaluation of option two reveals risks that need to be considered, particularly in the potential loss of providers and the potential absence of a targeted case management agency safety net. This could lead to a precarious situation where individuals may find themselves without community service providers to support them in their community. To mitigate these risks, it is crucial to analyze current provider capacity constraints and anticipate the needs of individuals during the transition phase. This foresight will be instrumental in strengthening the provider network and ensuring continuity of care. Additionally, KDADS must devise a robust plan to address situations where a targeted case management agency is unavailable, ensuring that no individual is left without access to this essential service.

### PCG Recommendation:

Option two is similar to option one, however, presents greater risks. Option two does not provide a safety net for individuals when there is not a targeted case management agency/independent targeted case manager who can provide services, which leaves the individual without targeted case management services. This is a significant risk to individuals who are desperately in need of services to maintain in their community and not become at risk of institutionalization.

## COMPLIANCE OPTION 3

Targeted case management and direct services can be performed by all agencies but not for the same individual.

Suggested roles and responsibilities are as follows:

| ROLE | RESPONSIBLE PARTY |
|---|---|
| Oversight/Quality Assurance | CDDO and State |
| Training | State and Agencies |
| Eligibility | CDDOs |
| Four Targeted Case Management Functions | CDDOs, Waiver providers, independent targeted case managers and targeted case management only agencies |
| Direct Services | CDDOs, Waiver providers, independent targeted case managers and targeted case management only agencies |

### Advantages

Option three aligns closely with the current structure and presents several advantages. ***Maintaining a familiar framework minimizes disruption and the potential loss of providers. This stability is crucial for sustaining a strong provider network, which is essential for delivering consistent and reliable services. Furthermore, it allows for a smoother transition and adaptation process for all providers involved.***

### Disadvantages

Option three presents several challenges that call for careful consideration. In scenarios where providers offer a range of services, it will be crucial to maintain a clear separation of those services to ensure compliance with federal regulations. The implementation of robust firewalls and mitigation strategies is essential in preventing any conflicts of interest, especially when the same provider offers both direct services and targeted case management services. For the state to consider this option they would need to heighten the level of state staff oversight to verify that providers are adhering to the strictly mandated separation of services. This in turn could lead to sophisticated monitoring systems and possibly additional training for oversight staff to effectively manage and enforce the firewalls. The increased monitoring difficulty could lead to oversight issues, potentially affecting the quality and consistency of services provided. The heightened effort required from KDADS could strain resources, necessitating a reallocation from other areas or the creation of new positions to manage the workload effectively. The complexity in distinguishing between agencies may result in blurred lines of accountability, making it harder to pinpoint responsibilities when issues arise.

Implementing firewalls is a critical step to prevent conflicts of interest, but it also adds another layer that could slow down the processes. The onus on individuals and families to verify the absence of conflicts of interest when changing providers or case managers could be burdensome, possibly deterring them from seeking better suited services. Each of these factors must be weighed against the potential benefits of option three to determine its viability.

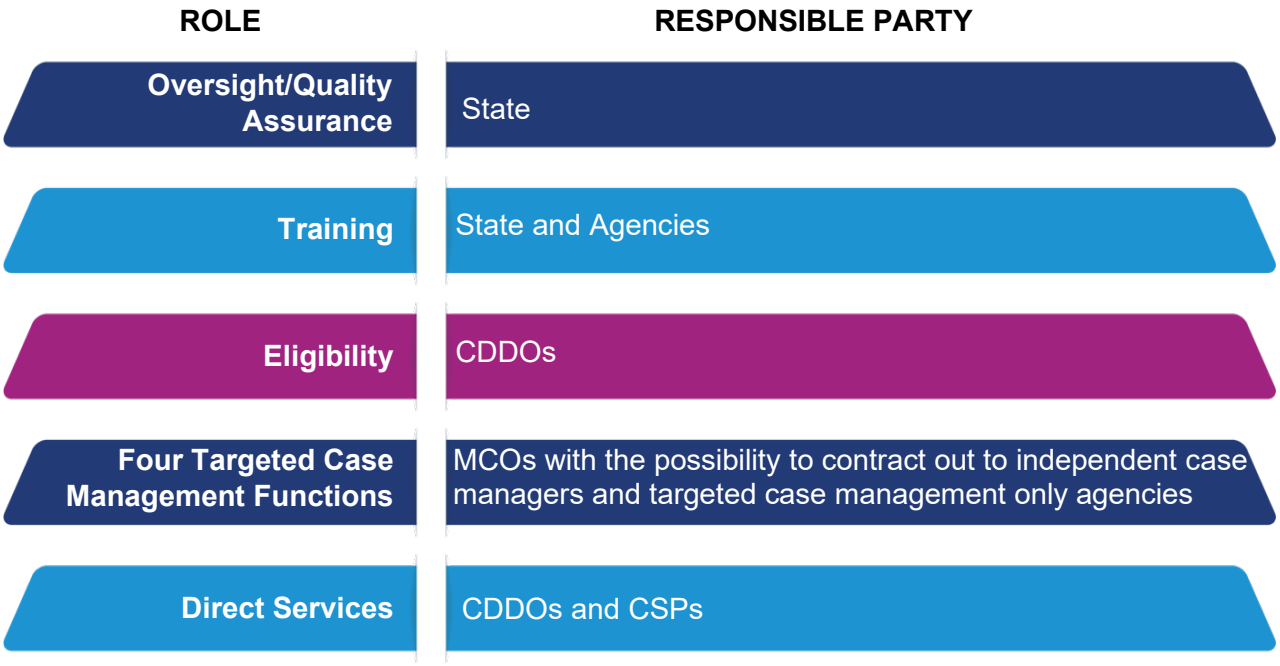
### PCG Recommendation:

PCG does not recommend KDADS adopt this option for compliance. This option has many oversight requirements that would be required of the state to inherit that they do not have the capacity to support. This option would require consistent oversight of each agency to ensure they are not serving an individual in both direct services and targeted case management.

## COMPLIANCE OPTION 4

Targeted case management becomes a function of the MCOs only.

Suggested roles and responsibilities are as follows:




### Advantages

Option four presents a unique approach by proposing the outsourcing of independent targeted case management services. For this option to be considered the MCOs would have to agree to meet all HCBS requirements. This structure could potentially streamline state monitoring processes. Moreover, it introduces a safety net, ensuring that MCOs provide targeted case management where there is a lack of willing and qualified targeted case management providers. This option could also enhance service coverage, ensuring that no individual in need is left without targeted case management.

### Disadvantages

The transition of targeted case management services to MCOs presents several challenges. One significant concern is the potential loss of targeted case management providers, as MCOs may decide to integrate targeted case management services in-house, potentially reducing the number of independent and agency-based case managers. This shift could result in services being provided by entities lacking experience in delivering critical community services. Moreover, such a transition necessitates amendments to the state MCO contracts, which may not align with existing contract cycles and would require the consent of the MCOs.

**PCG Recommendation:** This option was not presented to stakeholders because KDADS determined it would not be a viable option prior to stakeholder meetings.

# CONSIDERATIONS

Public Consulting Group LLC (PCG) developed the below considerations based on data and information gathered from the targeted case management study. Implementation of these considerations will support the Kansas Department for Aging and Disability Services (KDADS) in not only complying with federal requirements, but creating a more efficient and effective system and experience for individuals with intellectual and developmental disabilities (I/DD).

## AFFILIATION AGREEMENTS

The complexity of maintaining multiple affiliation agreements with various CDDOs presents a significant challenge for community service providers (CSP). These agreements, which are essential for ensuring compliance with state requirements vary from one CDDO to another, leading to a diverse range of stipulations that providers must adhere to. This diversity can provide a barrier to service providers' ability to expand their services into new catchment areas, as they must navigate the different requirements of each CDDO's agreement. The process involves an increased level of record keeping, reporting, inspections, understanding the reimbursement protocols, and complying with dispute resolution procedures along with other miscellaneous requirements.

KDADS should consider standardizing the affiliation agreements as it would limit the barriers faced by community service providers. A unified approach could potentially streamline this process, reducing the administrative burden on the providers and allowing them to focus on service delivery rather than navigating varied contractual obligations. Standardization may also facilitate more equitable service provision across different catchment areas, ensuring that all individuals have access to consistent and high- quality support regardless of their location.

Additionally, a standardized affiliation agreement could lead to improved efficiency within CDDOs themselves, as they would be operating under a common set of rules and expectations. This could increase collaboration between the CDDOs and CSPs, leading to a more integrated and cohesive service network. By evaluating and potentially standardizing provider affiliation agreements, KDADS could play a pivotal role in removing the barriers that currently impact the provider capacity growth within the community support sector.

## ROLES AND RESPONSIBILITIES

The delineation of roles and responsibilities between care coordinators and targeted case managers is a critical component in the efficient delivery of services. The existing KDADS document that outlines these roles is a valuable resource, but the feedback from providers indicates a need for an update to reflect current practices and reduce redundancy. It became apparent that the overlap in tasks and meetings not only burdens the care coordinators and targeted case managers but also the individuals and families who experience repetitive interactions.

An updated document should aim to clarify the distinct functions of care coordinators and targeted case managers, ensuring that each role is clearly defined and that their efforts are complementary rather than duplicative. Updating the roles and responsibilities document would involve a thorough review of the current document, engagement with stakeholders to gather insights and incorporation of best practices from successful models similar to the Kansas system. The goal would be to streamline processes, enhance collaboration, and ultimately improve the experience and outcomes for the individuals and families served. The document should serve as a dynamic document that is adaptable to the evolving landscape.

## COLLABORATION WITH CMS

Collaboration between KDADS and CMS is a pivotal aspect of ensuring compliance with conflict free case management. Developing and establishing a robust relationship with Kansas' representative can facilitate a smoother transition and adherence to the required milestones for compliance. This is significant in the context of developing the new Community Supports Waiver, where CMS' approval hinges on the demonstration of a comprehensive plan towards compliance and tangible progress.

Engaging in a discussion with CMS about the high-level plan prior to formal submission of waiver amendments and a new waiver application can provide an opportunity for preliminary feedback and guidance, potentially streamlining the approval process. It is essential that KDADS efforts are aligned with CMS's expectations, which includes compliance with conflict free case management. Additionally, the development process of the Community Supports Waiver should be approached with careful planning, ensuring that all services and supports are in a compliant state. Adhering to these guidelines and fostering open communication with CMS, KDADS can enhance the likelihood of successful compliance and waiver development.

## STATUTE, REGULATION, AND POLICY UPDATES

Compliance with the federal regulations is a multi-layered process that requires meticulous planning and execution. KDADS must first choose a path to compliance that aligns with the state's goals and legal framework. Following this, a comprehensive evaluation of existing statutes, regulations, and policies will be essential to identifying areas that require updates. The assessment will form a foundation for subsequent actions.

Once the necessary modifications are pinpointed, KDADS should develop a detailed timeline and roadmap. This strategic plan will guide the enactment of new statutes, the approval of regulations, and the implementation of policy updates. It is crucial to acknowledge that these changes often involve multiple levels of approval which can extend the timeframes for adoption.

Early determination of the required updates will expedite the overall compliance process. The sooner the state begins the evaluation process and identifies what needs to be done the quicker the system structure can align with the new compliance requirements.

It is also extremely important for KDADS to consider the stakeholders involved in this transition. Effective communication and collaboration with legislative bodies, regulatory agencies, and other affected stakeholders will be key for a smooth transition. By addressing current laws and policies, developing a clear action plan, and engaging with all necessary stakeholders, the state can efficiently navigate the complexities of regulatory updates and achieve compliance in a timely manner.

## STATEWIDE TRAINING

The need for a comprehensive statewide training plan is clear, as all stakeholders repeatedly expressed a desire for such a program to be implemented. The absence of training for over a decade has likely contributed to inconsistencies in service delivery across the state. Developing a standardized training curriculum would be a significant step towards ensuring that all agencies are equipped to provide a high level of services. Stakeholders expressed that the following agencies could benefit from a standardized training curriculum:

- MCO
- CDDO
- Targeted Case Managers
- CSP

Stakeholders also expressed topics of interest that they would like for the state to provide which include but are not limited to the following:

- Person Centered Thinking and Practice
- Billable vs Non-Billable Activities
- Eligibility Assessment Standardization
- Support Planning
- Risk Assessments
- Prior Authorization

Having a statewide training program in place would not only enhance the skills of their staff but also ensure that individuals and families receive a consistent level of service, no matter what CDDO, MCO, targeted case management or CSP they are working with.

## DUPLICATION OF FUNCTIONS AND ACTIVITIES

The targeted case management study highlighted duplication in the functions and activities of CDDOs, MCOs, and targeted case managers. The duplication not only effects the agencies but more importantly effects the individuals receiving services. All agency types identified a misunderstanding about their roles and involvement in the BASIS and other assessments. To enhance efficiency and clarity, it is important to delineate each agency's role and responsibility.

Another mention of role delineation from agencies was determining which agencies are responsible for options counseling and ensuring that there is a process in place for the agencies to have conversations with individuals seeking services. If options counseling is the responsibility of CDDOs, targeted case managers and other waiver assessing entities it is important to include

this in the roles and responsibilities of each agency so that it is consistent across the state. Standardization of processes across various regions ensures uniformity in service delivery, which is important for the efficiency and effectiveness of services provided by CDDOs, MCOs, and targeted case managers. Establishing clear guidelines about the intake, eligibility, assessment, and support planning tasks, will ensure the individuals seeking or receiving services have a consistent experience statewide. Additionally, delineating responsibilities and required timelines between targeted case managers and MCOs can significantly reduce task duplication and confusion. A well-defined division of labor and clear understanding of each agency's responsibilities are fundamental for fostering collaboration between the two agencies and enhancing the overall service provision for those seeking HCBS services.

### TARGETED CASE MANAGEMENT BILLING

Throughout the study, targeted case managers expressed concerns and difficulties regarding targeted case management billing, the need for clear billing criteria guidance, and a well-defined delineation of roles and responsibilities. To address these issues, it is essential to develop comprehensive documentation that outlines the requirements for case notes, specifically services eligible for billing, and provides detailed billing criteria guidance. This will not only ensure accuracy in billing practices across the state but also facilitate a better understanding of the distinct functions of targeted case management and MCO billable services. Lastly, establishing a clear framework for the roles and responsibilities of targeted case managers and MCOs could reduce any service overlaps and improve the accuracy of billing between the two agencies.

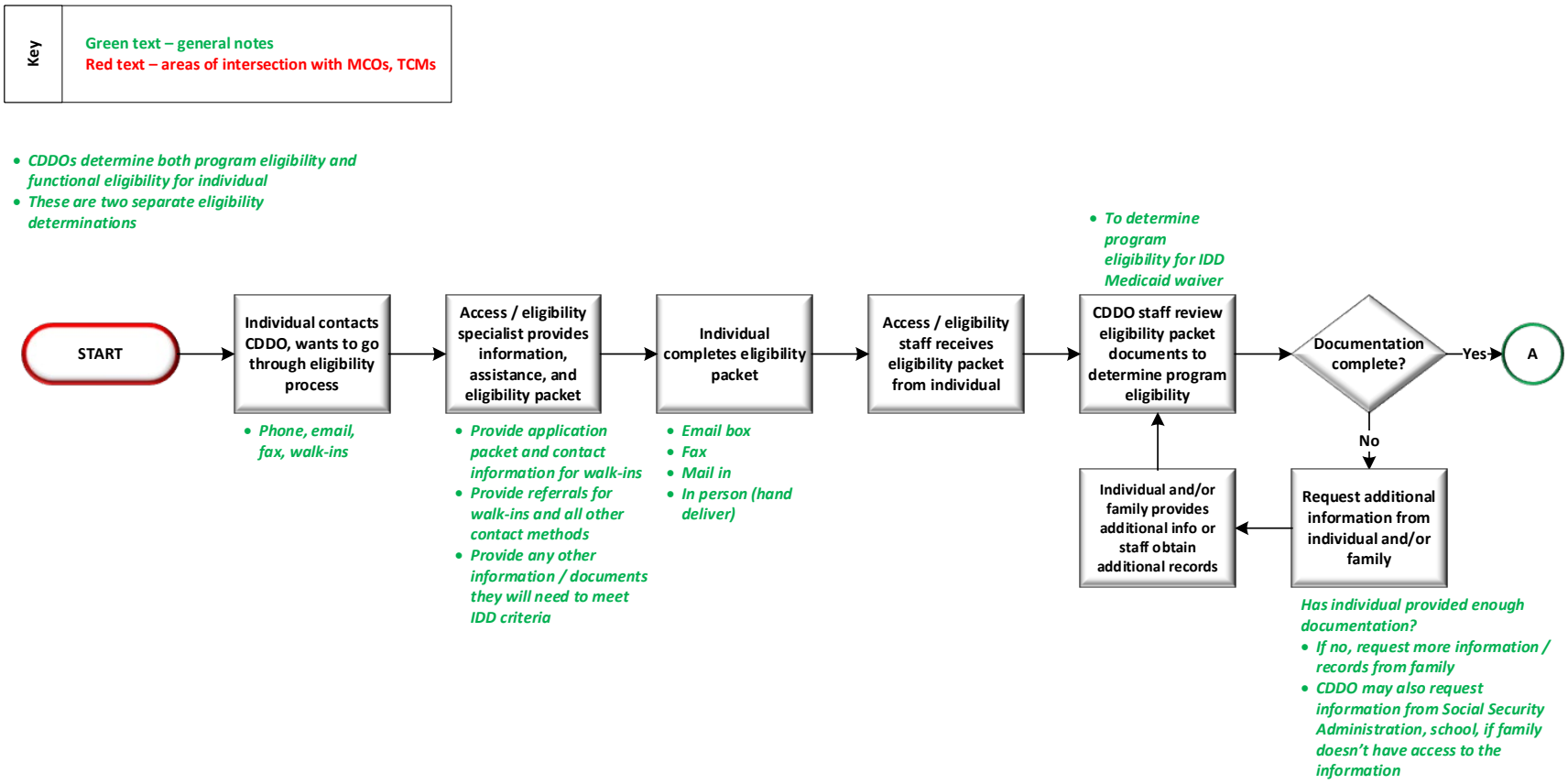
Targeted case managers also expressed frustration about the requirement to bill targeted case management in 15-minute unit increments. While KDADS recently increased the targeted case management reimbursement rate, they should consider a review of the reimbursement methodology. Other options, such as a daily or monthly rate, could decrease the administrative burden of billing to targeted case managers and subsequently increase the quality of targeted case management services, as targeted case managers can be more focused on providing targeted case management. KDADS may also consider a review of the reimbursement rate, to ensure it adequately accounts for non-billable service time.

## ACKNOWLEDGEMENT

Public Consulting Group LLC would like to acknowledge individuals, families, guardians, Community Developmental Disability Organizations, Managed Care Organizations, targeted case managers, community support providers, and the Kansas Department for Aging and Disability Services for their time, commitment, and participation in the Targeted Case Management Study. Their input and feedback was invaluable in the support of developing options for compliance and additional consideration for the State of Kansas.

# APPENDIX A: CDDO BUSINESS PROCESS MAPS

## CDDO – Intake / Program Eligibility



# CDDO – Intake / Program Eligibility & Functional Eligibility

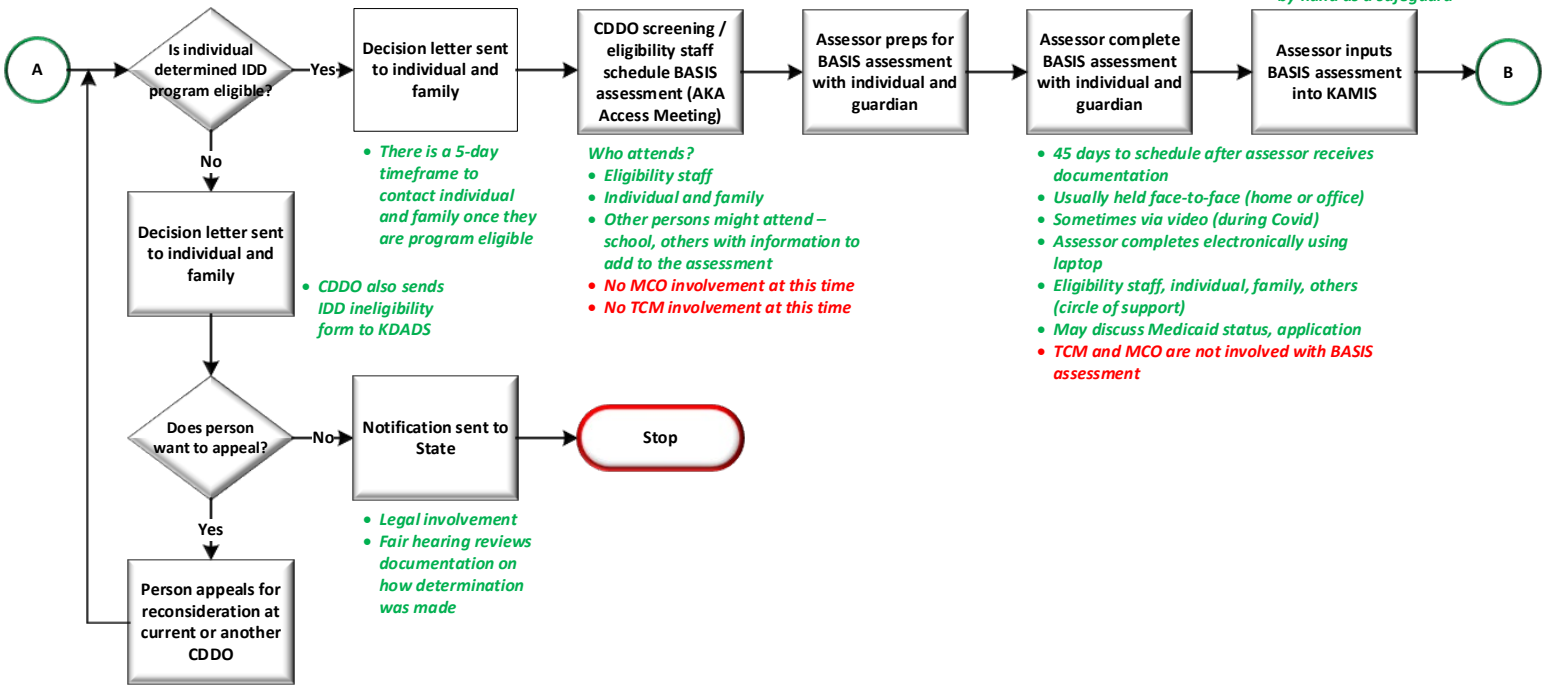
*Eligibility for waiver:*
- *Must be 5 years of age or older*
- *Have intellectual disability that began before the age of 18*
- *Have a diagnosis of a developmental disability that began before the age of 22*
- *Must be determined program eligible by the Community Disability Determination Organization*
- *Meet the Medicaid long-term care institutional threshold score*
- *Be financially eligible for Medicaid*

*Days from when individual is determined program eligible to holding assessment meeting:*
- *5 days to contact person/guardian*
- *45 business days to finish eligibility (hold BASIS assessment meeting)*

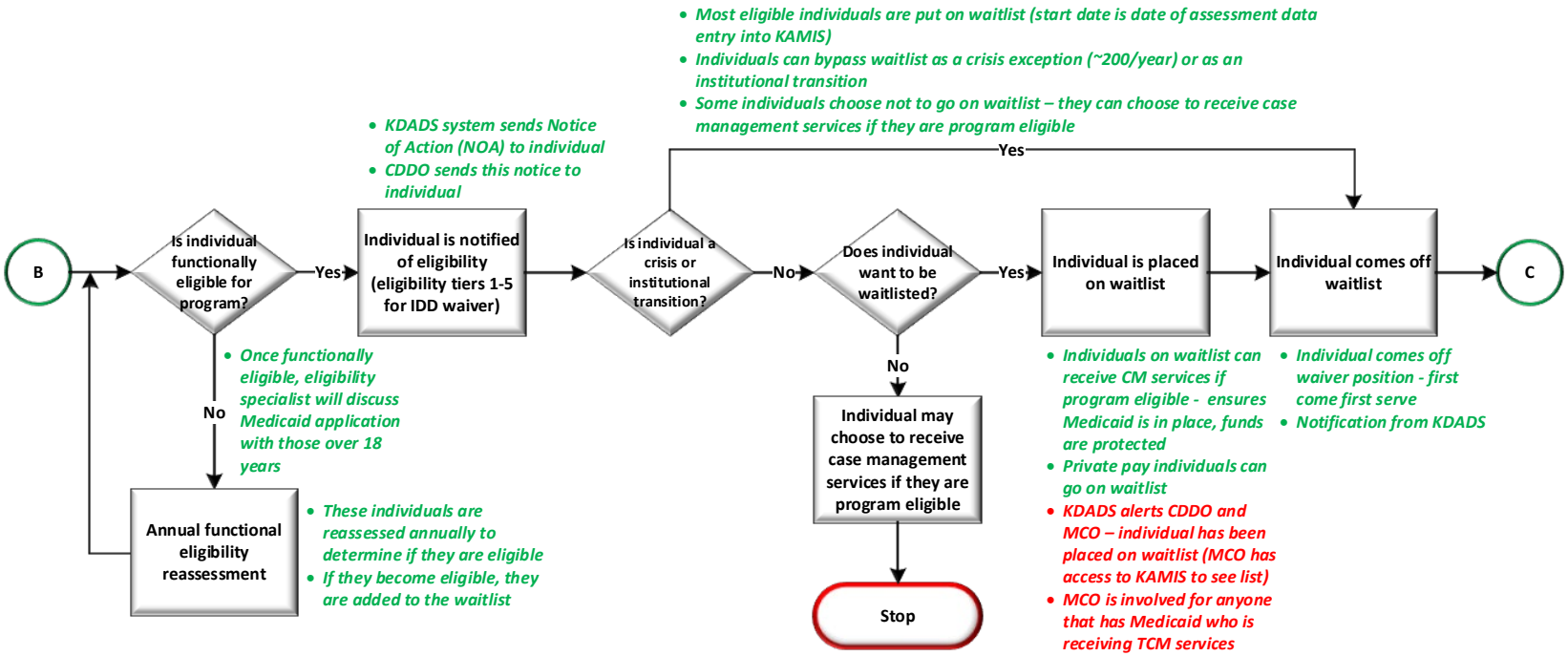
- *If individual is determined program eligible process moves to functional eligibility*
- *Those who are program eligible can receive case management services*
- *Case manager helps ensure Medicaid is in place and funds are protected*
- *TCM becomes involved here if a person is Medicaid eligible and / or is receiving case management services*
- *MCO is also involved*

*Prior to meeting the Assessor:*
- *Reviews doctor visits*
- *Information from behavior specialist (Behavior Support or Intervention Plans)*
- *Health records, other health documents*
- *School/IEP information*
- *Behavior intervention /Support plan*

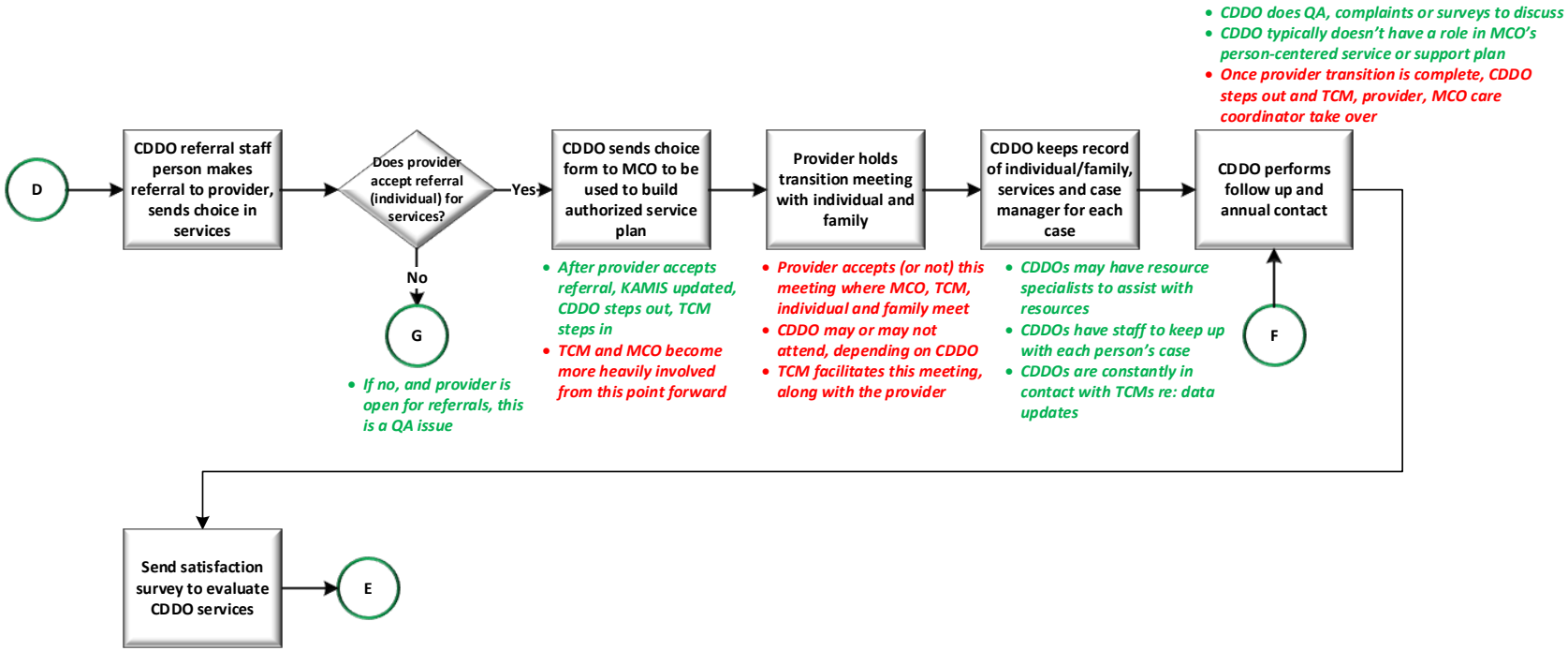
- *Can be uploaded automatically but some CDDOs would rather data enter information by hand as a safeguard*



# CDDO – Intake / Functional Eligibility



# CDDO – Ongoing Services (Monitor / QA / Report)



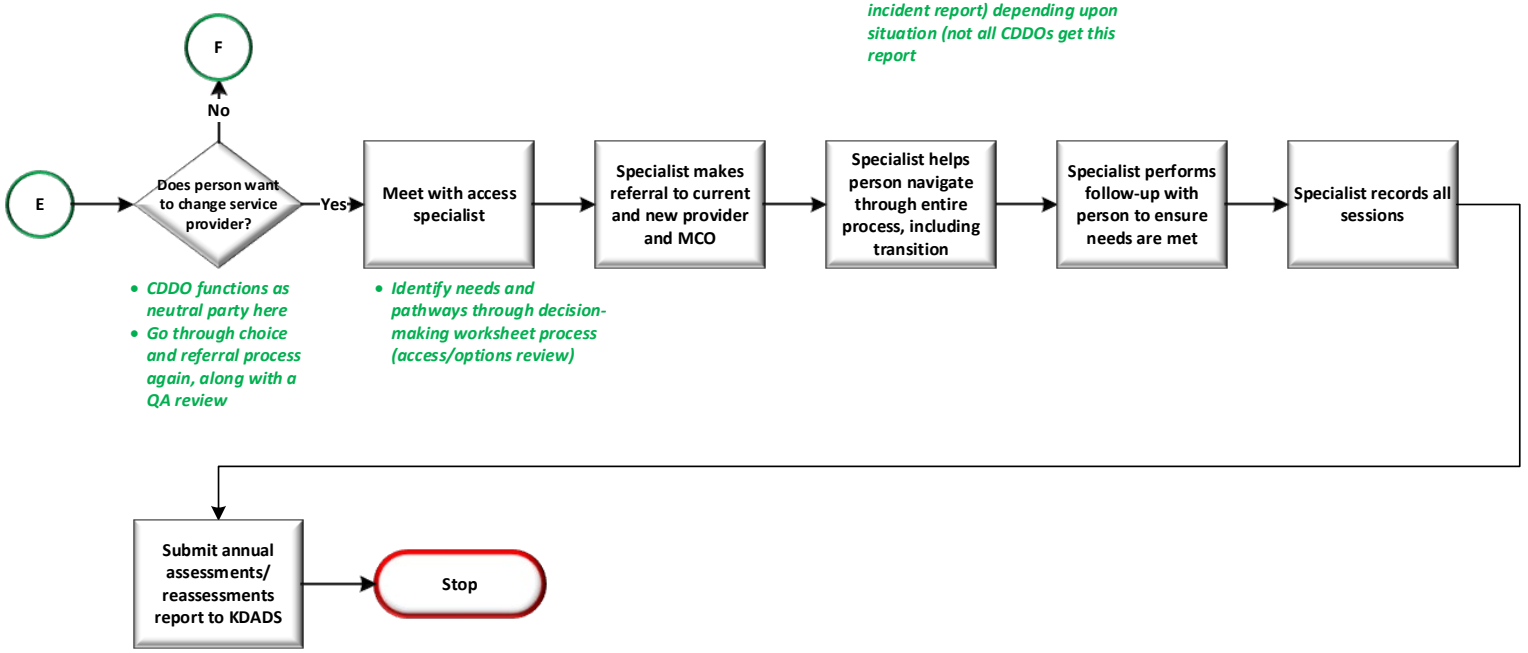
# CDDO – Ongoing Services (Monitor / QA / Report)

*CDDO QA staff responsible for:*

- *Annual provider reviews*
- *Reviewing licensed services (visits)*
- *Staff may Investigate issues raised by the TCM, the person served, family. May follow-up with, adverse incident (AIRES report or critical incident report) depending upon situation (not all CDDOs get this report*

*CDDO reporting responsibilities:*

- *Quarterly complaint tracking*
- *Quality Review Tracking (QRT) – random sample from KDADS (documentation completeness evaluation)*
- *Options counseling follow-up, back and forth between CDDO and MCO*

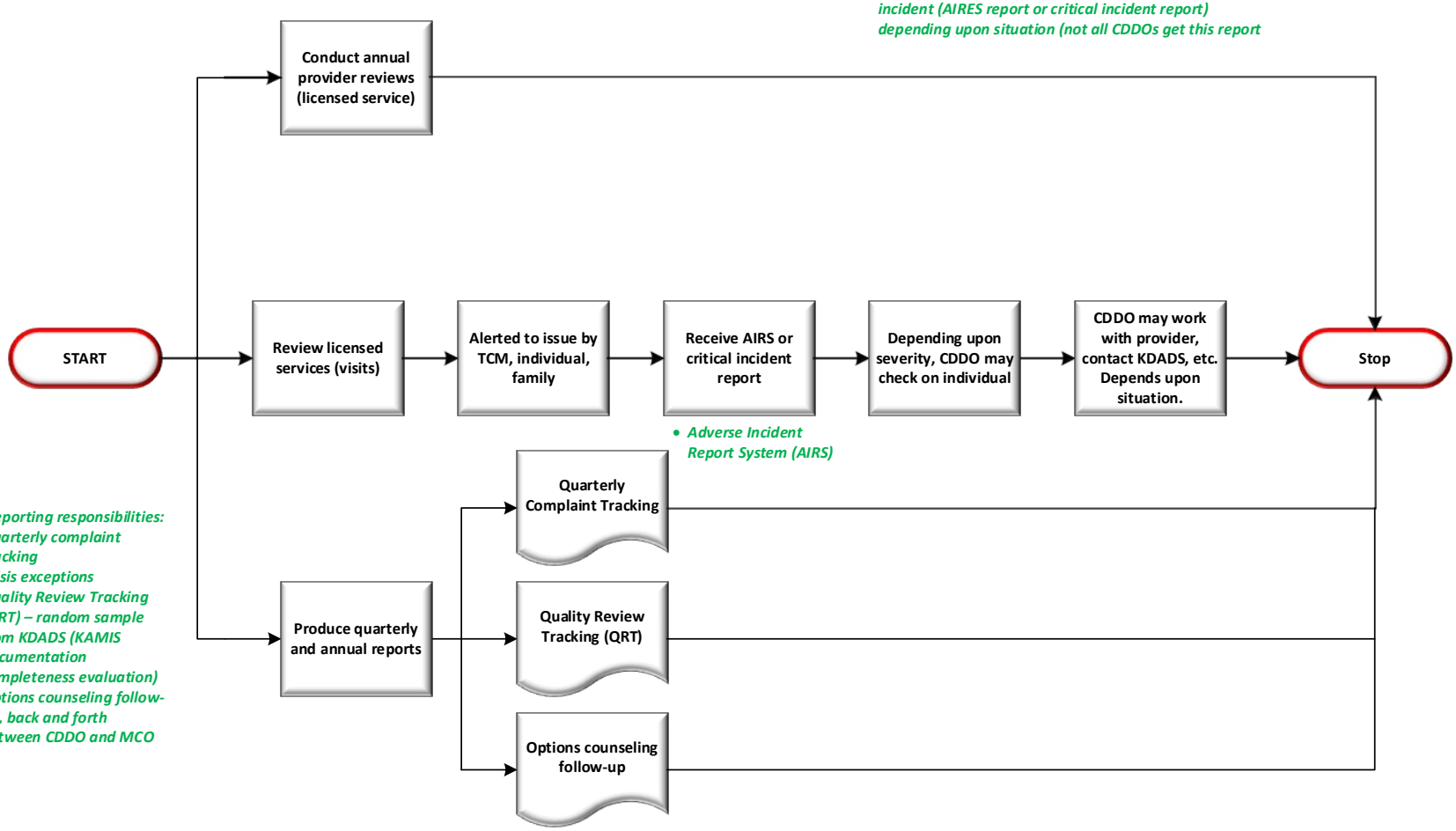



- *CDDO functions as neutral party here*
- *Go through choice and referral process again, along with a QA review*

- *Identify needs and pathways through decision-making worksheet process (access/options review)*

# CDDO – Ongoing Services (Monitor / QA / Report)

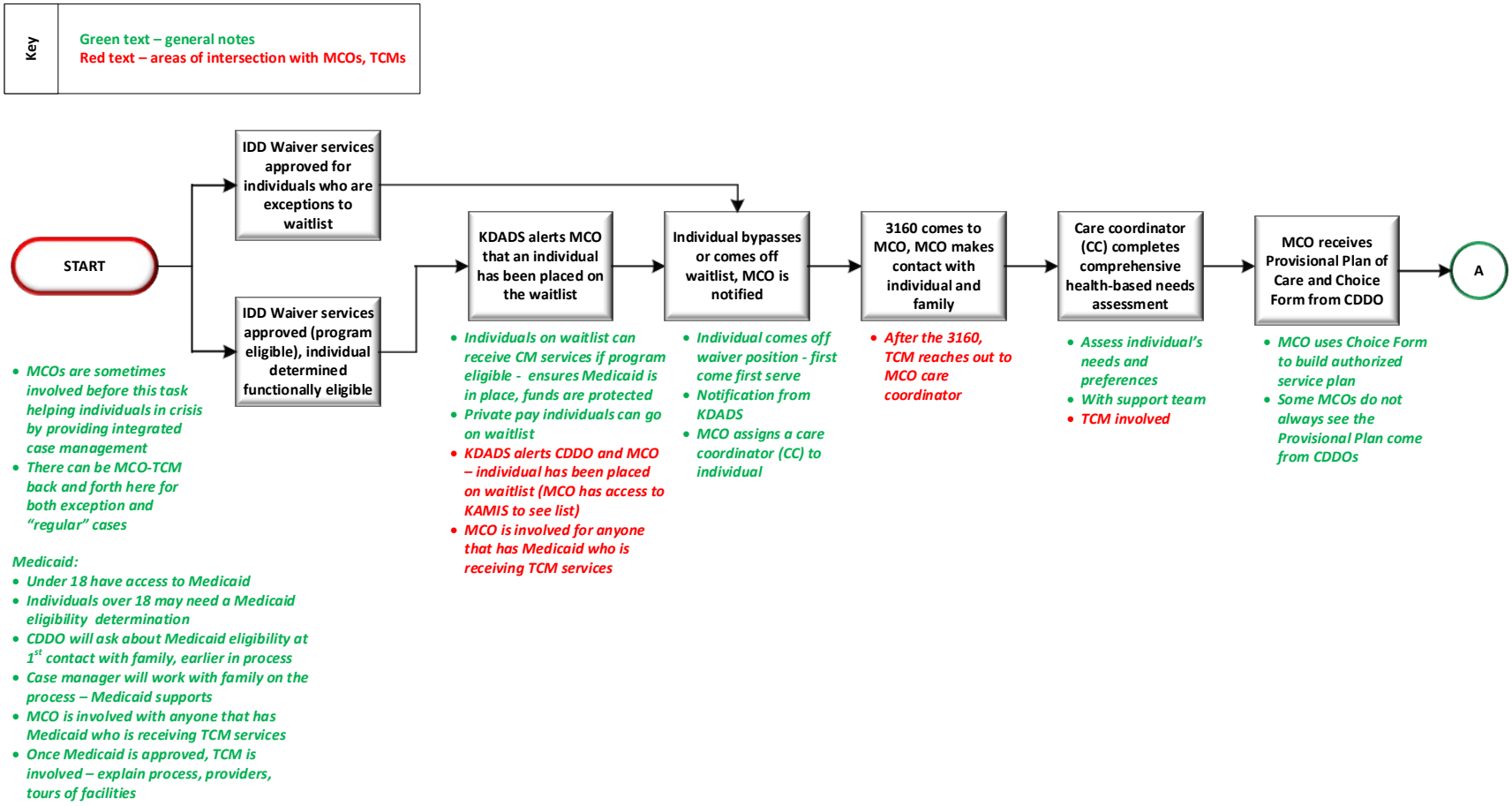
*CDDO QA staff responsible for:*
- *Annual provider reviews*
- *Reviewing licensed services (visits)*
- *Staff may Investigate issues raised by the TCM, the person served, family. May follow-up with, adverse incident (AIRES report or critical incident report) depending upon situation (not all CDDOs get this report*



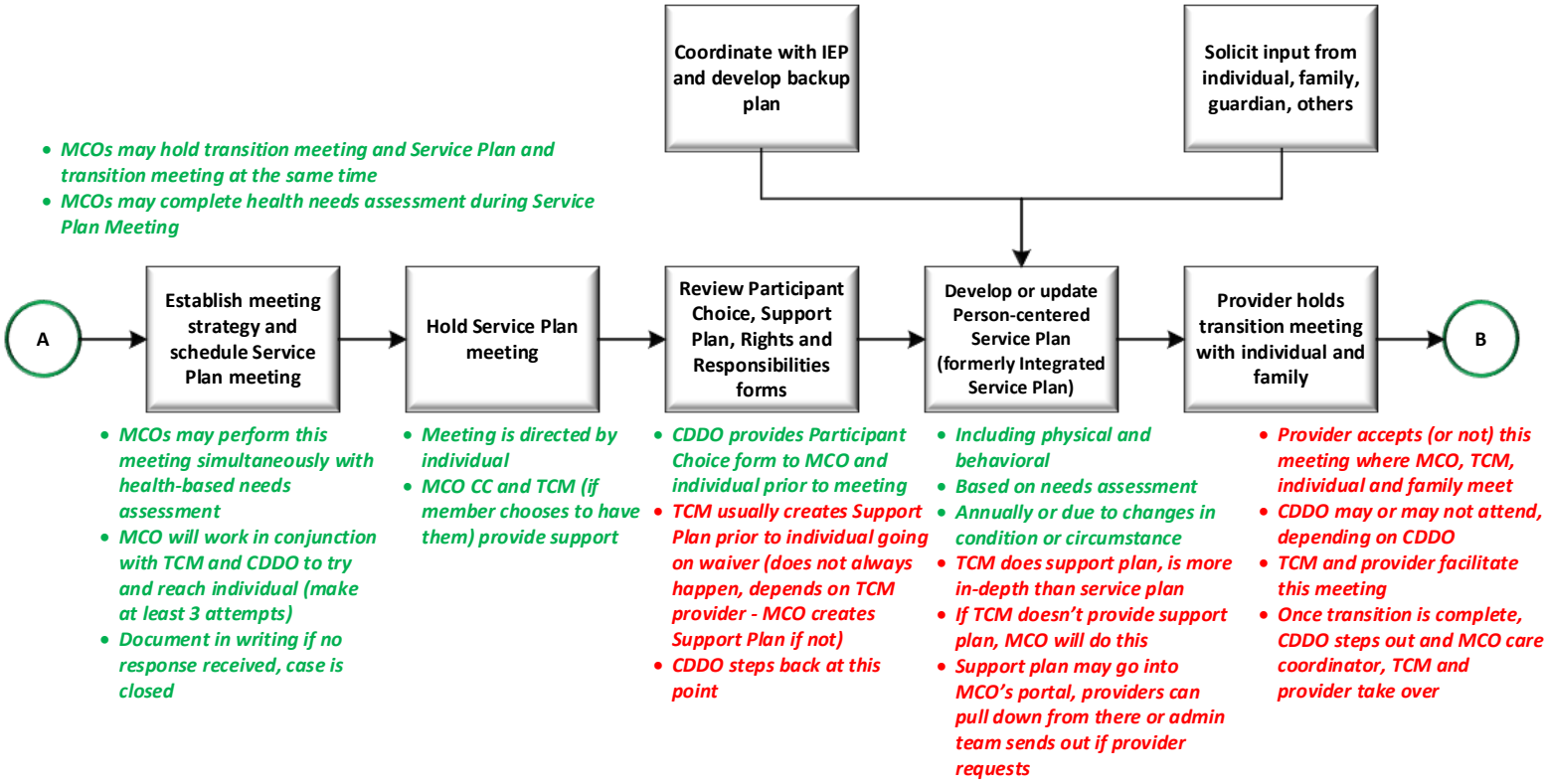

*CDDO reporting responsibilities:*
- *Quarterly complaint tracking*
- *Crisis exceptions*
- *Quality Review Tracking (QRT) – random sample from KDADS (KAMIS documentation completeness evaluation)*
- *Options counseling follow-up, back and forth between CDDO and MCO*

# APPENDIX B: MCO BUSINESS PROCESS MAPS

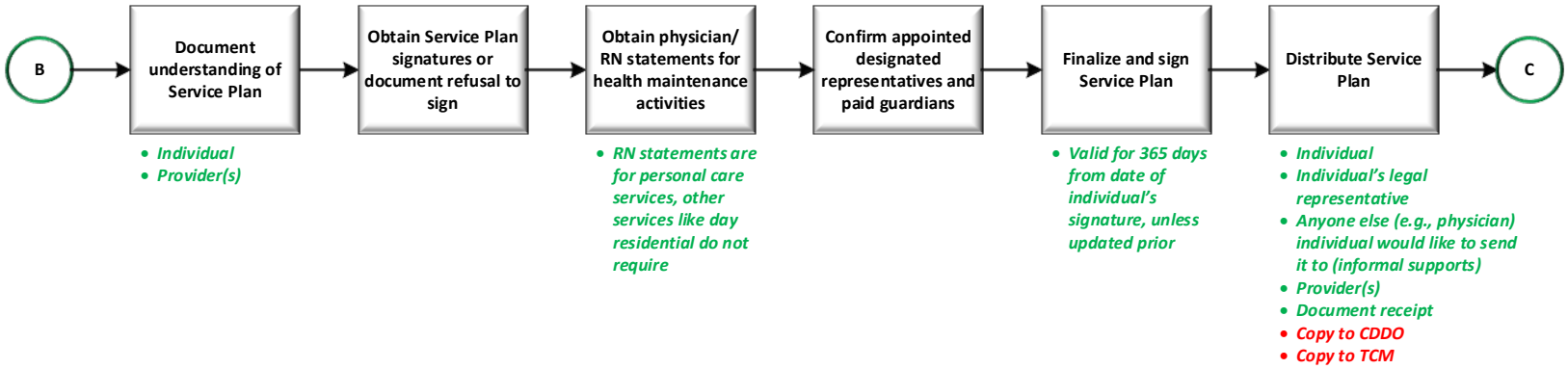
## MCO – Intake / Eligibility / Assessment



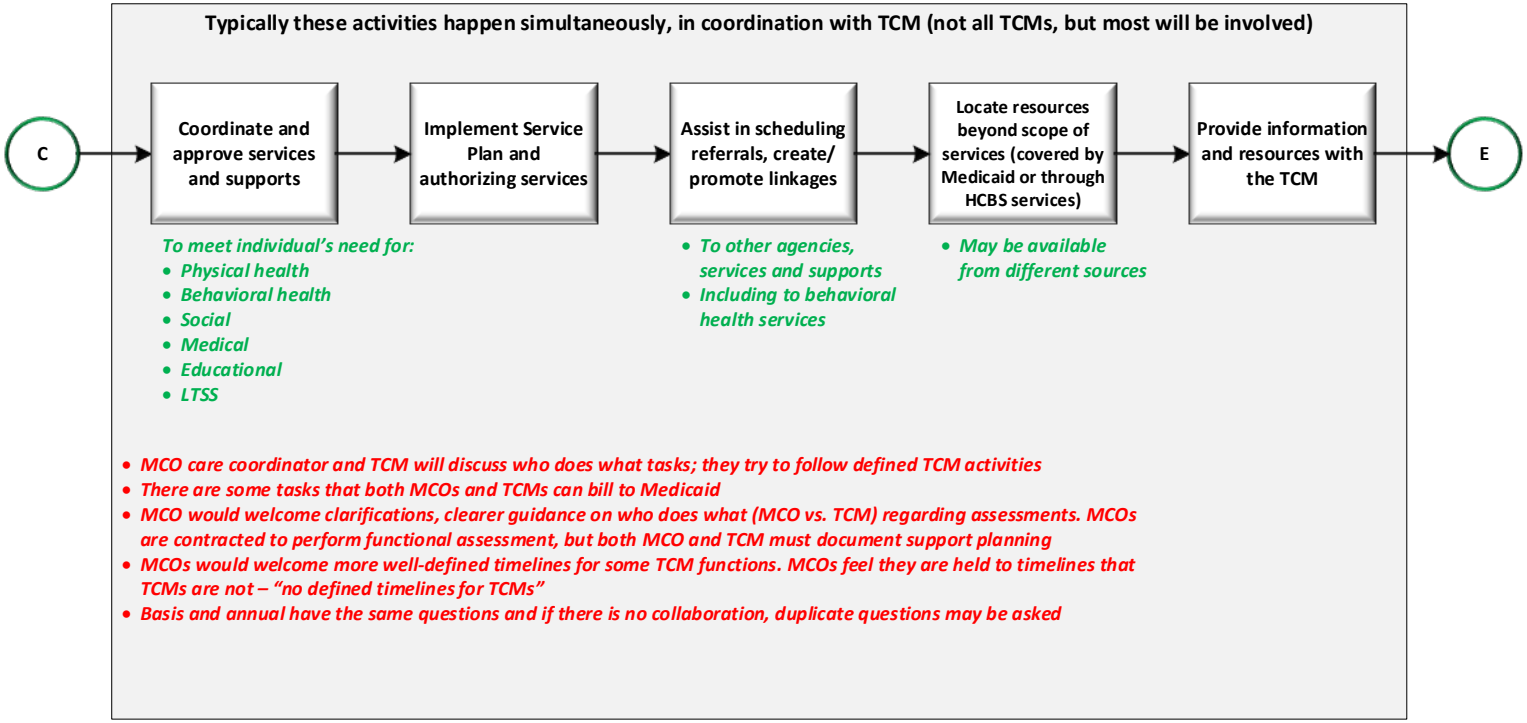
# MCO – Planning



# MCO – Planning

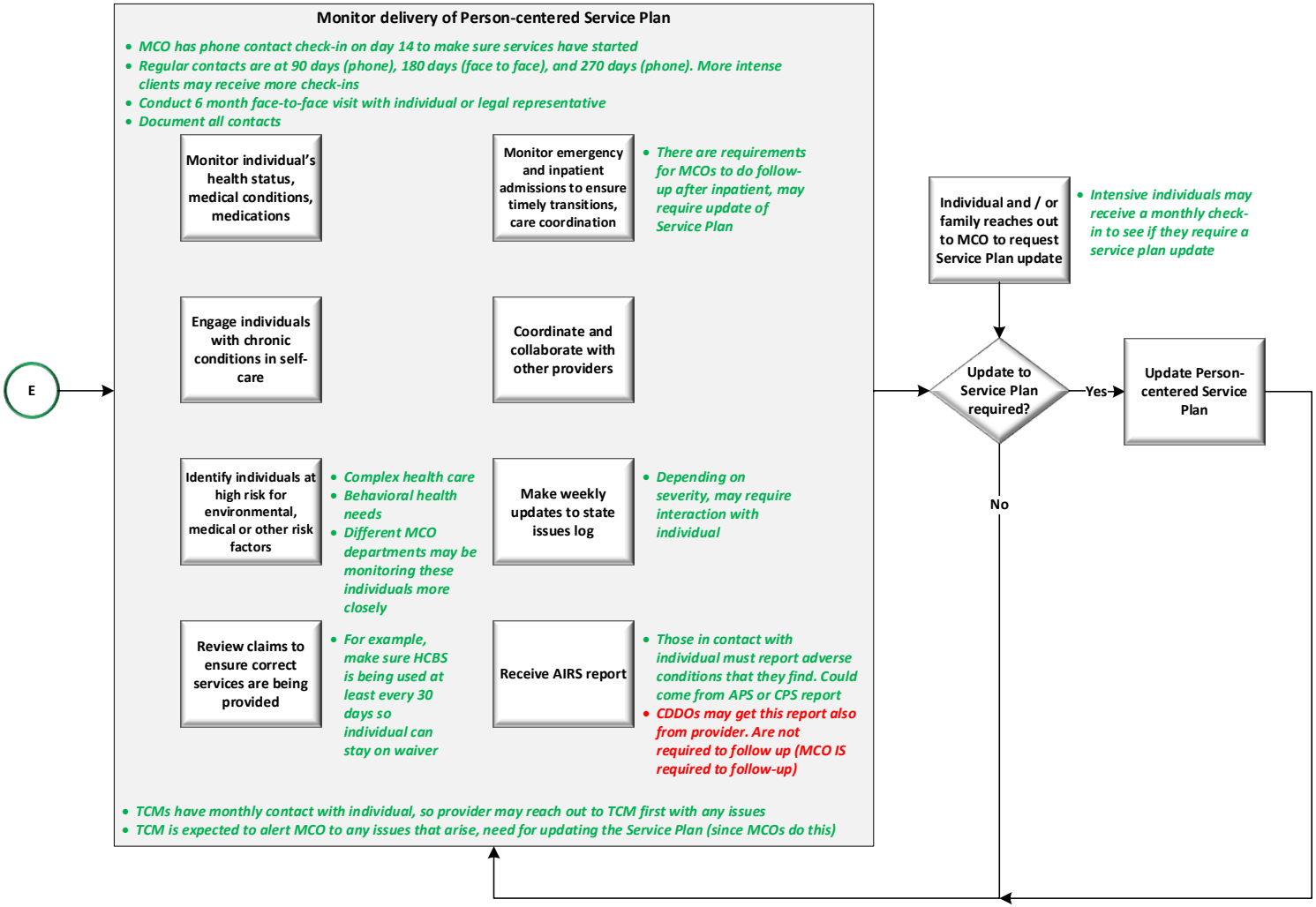


# MCO – Ongoing Services



# MCO – Ongoing Services (Monitor / QA)

*List of to-do's after starting services:*
- *Individual must use services at least monthly*
- *Annual assessment to determine if needs have changed*
- *Annual Person-centered Service Plan*
- *Annual renewal of KanCare application*
- *Notify clearinghouse, waiting list entry point, and provider if individual moves or changes information*
- *Contact access entity to change any information*



# MCO – Reporting and Reassessment / Redetermination

**Reassessment / Redetermination**

- *MCOs don't have a formal role here*
- *CDDO performs functional eligibility*
- *MCOs might perform outreach reminders to individuals*
- *State is responsible for sending out financial eligibility redetermination (done via mail). MCOs may remind the individual that they need to send back this paperwork or risk becoming ineligible*

**Reporting**

- *There are currently 101 contractually required, mandatory reports that MCOs must submit to KDHE (see next page for a summary of these reports)*
- *Some reports might be redundant. MCOs should review report list and point out these area*

*MCO reports include:*

- *AIRS reporting*
- *Inpatients or incarcerations to KDADS using the 3161*
- *Monthly plan of care cost (specific to IDD)*
- *MCOs mentioned some of their reports are redundant*

## MCO – Reporting and Reassessment / Redetermination

| Monthly | Quarterly | Bi-Annual | Semi-Annual | Annual | Annually by end of first quarter following year being evaluated | As Needed | TBD | Weekly | Undefined or Blank | 90 days post contract award and annually thereafter | 90 days before the start of the contract year |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Grievances - Transportation** | Grievance and Appeal Reports(GAR)/ Appeals Resolution Timeframe | Medication Therapy Management Monthly Report | Quality Assessment and Performance Improvement Work Plan | Program Integrity Risk Assessment | Annual CONTRACTOR(S) Evaluation Report | Pended Claims Report | Input Type Control Listings | Encounter Submission Report | Service Coordination Caseload Report | Cultural Competency Plan | Monitoring and Notification of Provider Qualifications |
| **Preferred Drug List Report** | Title 21 Vaccine report | | | Customer Service Report, Member Services and Provider Services Phone Line Report, Telephone and Internet Activity Report Call Center Access and Responsiveness Report | | KanCare Claims Resolutions Log | Records of Non-processable Claims | KDHE Unified Log | | | |
| **Prior Authorization Pharmacy Summary** | Overview of Corporate Compliance Department Activity | | | Consumer Assessment of Healthcare Providers and Systems (CAHPS) Report | | | Exception Reports of Claims in Suspense in a Particular Processing Location for More Than a User-specified Number of Days | | | | |
| **Step Therapy Savings Report** | Payment Integrity Report | | | HEDIS Annual Reporting | | | Electronic Submission Statistics (as defined by the State) | | | | |
| **Prescription Prior Authorization Override Report** | Disclosure of Ownership | | | Staffing Contingency Plan Updates | | | Reports of Unsuccessful Transmissions and Claims / Encounters and Adjustments Errors or Rejections | | | | |

## MCO – Reporting and Reassessment / Redetermination

| Month | Quarterly | Bi-Annual | Semi-Annual | Annual | Annually by end of first quarter following year being evaluated | As Needed | TBD | Weekly | Undefined or Blank | 90 days post contract award and annually thereafter | 90 days before the start of the contract year |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Provider Participation - Adverse Actions Taken Against Providers** | Fraud and Abuse Report-MEMBER and PROVIDER | | | 5% Ownership Report | | | Timely Claims Processing | | | | |
| **Provider Participation - Adverse Actions Taken Against Providers** | Customer Service Report, Member Services and Provider Services Phone Line Report, Telephone and Internet Activity Report Call Center Access and Responsiveness Report | | | Continuity of Business Operations Plan | | | Top Claims Denial Reasons | | | | |
| **Verification of Services Provided** | Home and Community Based Services (HCBS) PCSP Report | | | Member Handbook Updates | | | Encounter Resolutions Log (CONTRACTOR(S)) | | | | |
| **Customer Service Report, Member services and Provider Services Phone Line Report, Telephone and Internet Activity Report Call Center Access and Responsive-ness Report** | Extraordinary Funding | | | Security Plan Updates | | | Problem Notification | | | | |
| **IDD Residential Policy** | Screening, Brief Intervention and Referral to Treatment | | | Insolvency Plan | | | CONTRACTOR(S) Daily Encounter Submission Report (CLM-0123-D Secured File Transfer Protocol (SFTP)) | | | | |

## MCO – Reporting and Reassessment / Redetermination

| Monthly | Quarterly | Bi-Annual | Semi-Annual | Annual | Annually by end of first quarter following year being evaluated | As Needed | TBD | Weekly | Undefined or Blank | 90 days post contract award and annually thereafter | 90 days before the start of the contract year |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **IDD Program Report** | Geographic Mapping Reports (Geo-Access) | | | Performance Bond | | | CONTRACTOR(S) Front End Billing (FEB) Pending File Report | | | | |
| **KanCare LTSS Oversight Report** | Network Adequacy (Provider Network Report) | | | Provider Manual Updates | | | New-Rejected and Accepted Claims | | | | |
| **RADAC Referral Reporting** | Network Adequacy Utilization | | | Final Independently Audited Financial Statements | | | Acceptance of FEB-Related Files | | | | |
| **Value Added Benefits** | HEDIS Annual Reporting (upon State request quarterly) | | | Health Insurance Provider Fee (HIPF_ form 8963 | | | Submission of Pre-Adjudicated Claim Copies | | | | |
| **In Lieu of Report** | Organizational Charts | | | Electronic Health Screen Report | | | Submission of Pre-Adjudicated Claim Copies | | | | |
| **Children and Youth with Special Health Care Needs (CYSHCN)** | Health Risk Assessments Report | | | HCBS Provider Qualifications and Training Status | | | | | | | |
| **Health Insurance Portability and Accountability Act (HIPAA) Monthly Summary** | Hysterectomies and Sterilizations Report | | | Schedule and Annual Report of Provider Training Sessions | | | | | | | |
| **Community Transitions** | Pay for Performance 2017 | | | Cultural Competency Plan (90 days post contract award and annually thereafter) | | | | | | | |
| **Foster Care Reporting** | Serious Emotional Disturbances (SED) Waiver Performance Measures-Quarterly | | | Member Advisory Committee | | | | | | | |

## MCO – Reporting and Reassessment / Redetermination

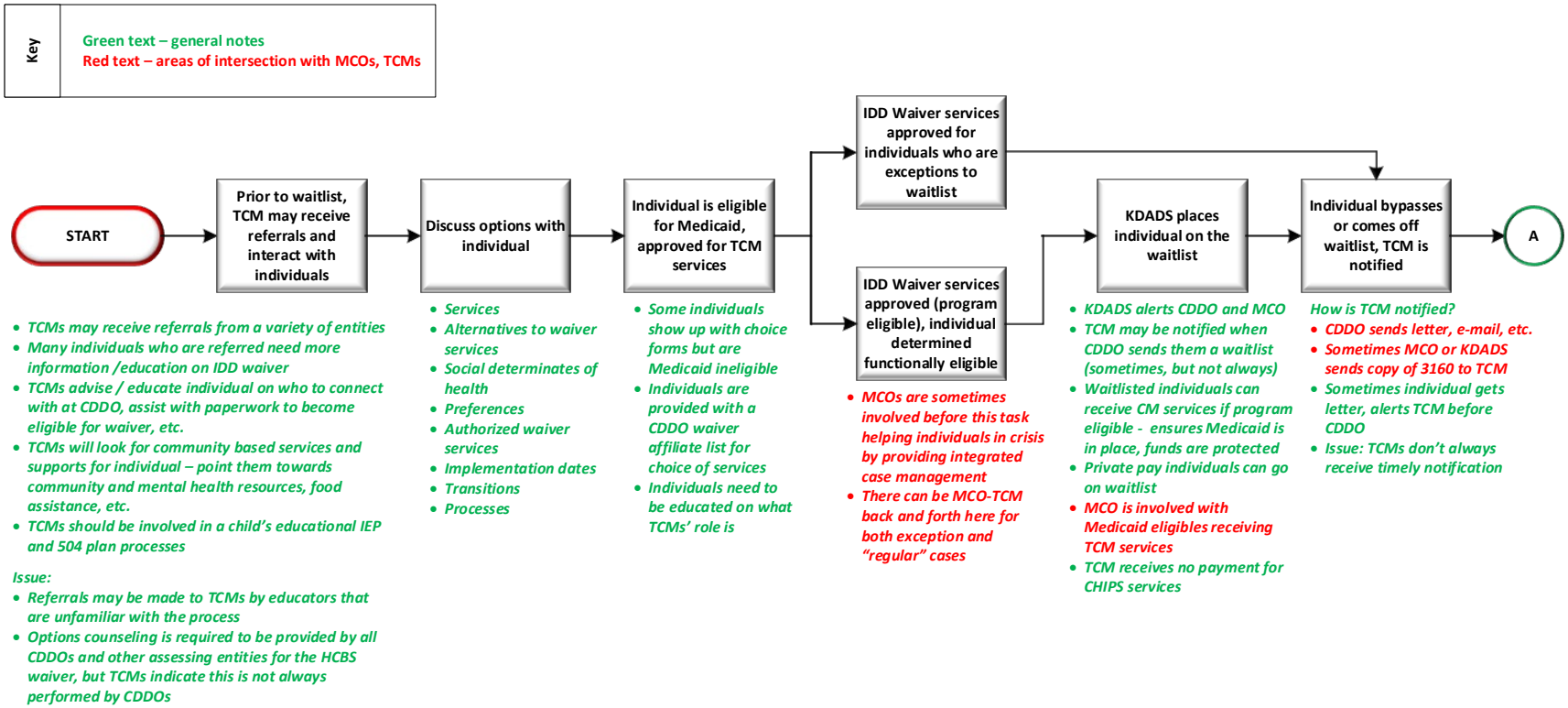
| Monthly | Quarterly | Bi-Annual | Semi-Annual | Annual | Annually by end of first quarter following year being evaluated | As Needed | TBD | Weekly | Undefined or Blank | 90 days post contract award and annually thereafter | 90 days before the start of the contract year |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **WORK Allocation Report** | Standard Terms and Conditions (STCs) Quarterly Report | | | | | | | | | | |
| **WORK Enrollment End Date Report** | Member Outreach and Educational Offerings Report | | | | | | | | | | |
| **WORK Good to Go (GTG) Report** | WORK ILC Billing Audit File | | | | | | | | | | |
| **Standard Services Preauthoriza-tion Decisions Report** | WORK Participant Funds Summary Reports | | | | | | | | | | |
| **Utilization of Services by Service Type and Average Service Utilization** | Performance Improvement Projects | | | | | | | | | | |
| **Financial Package - Monthly Edition** | Turnaround Time (TAT) Prior Authorization Report [Standard Services Preauthoriza-tion Decision Report (Service Authorizations, Service Denials, and Pending Service Authoriza-tions)] | | | | | | | | | | |
| **Inventory Management Analysis by Claim Type** | Quarterly KID NAIC Financial Report | | | | | | | | | | |
| **Death Data Match Reports-Providers Report** | Non-Participating Provider Report | | | | | | | | | | |

# MCO – Reporting and Reassessment / Redetermination

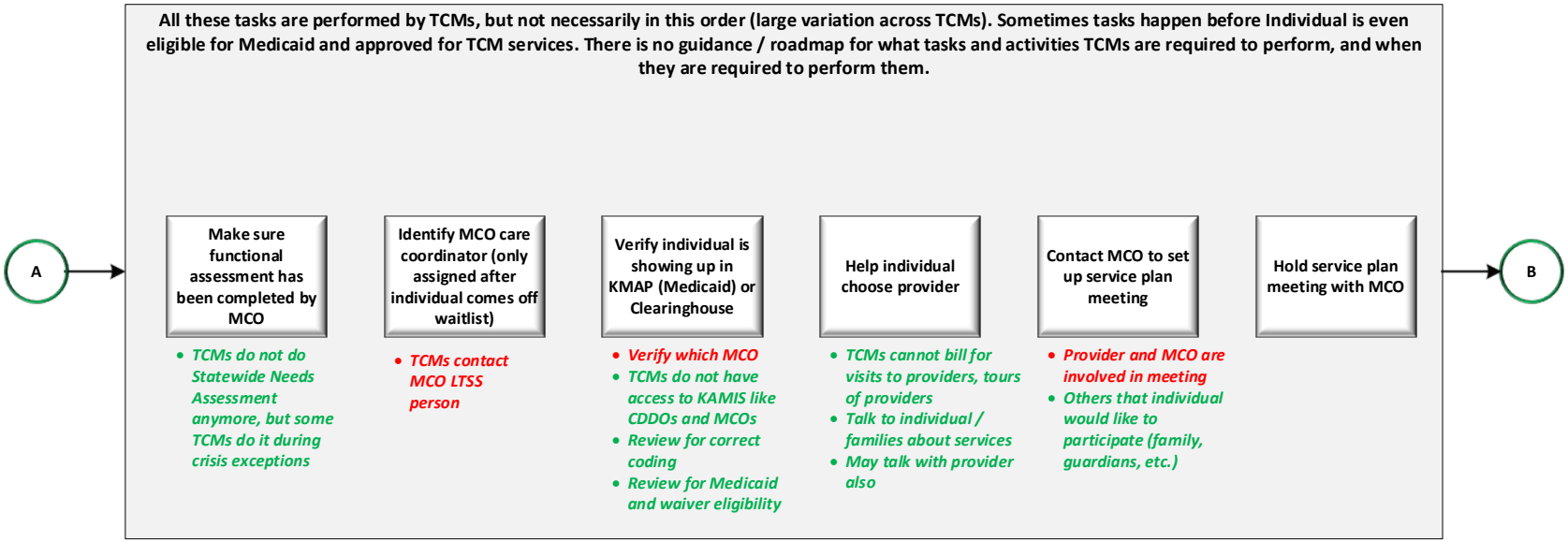
| Monthly | Quarterly | Bi-Annual | Semi-Annual | Annual | Annually by end of first quarter following year being evaluated | As Needed | TBD | Weekly | Undefined or Blank | 90 days post contract award and annually thereafter | 90 days before the start of the contract year |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Death Data Match Reports-Encounters After Date of Death (DOD) Report | Member Advisor Committ | | | | | | | | | | |
| New-Monthly Claims Processing Reporting | | | | | | | | | | | |
| New-Monthly Claims Processing Reporting - Timely Filing Statistics | | | | | | | | | | | |
| New-Monthly Accounts Receivables (ARs) Collections | | | | | | | | | | | |
| New-Adjustment or Corrected Claim Reporting | | | | | | | | | | | |
| Advance Pay Collection Referral Report | | | | | | | | | | | |

# APPENDIX C: Targeted Case Management Business Process Maps

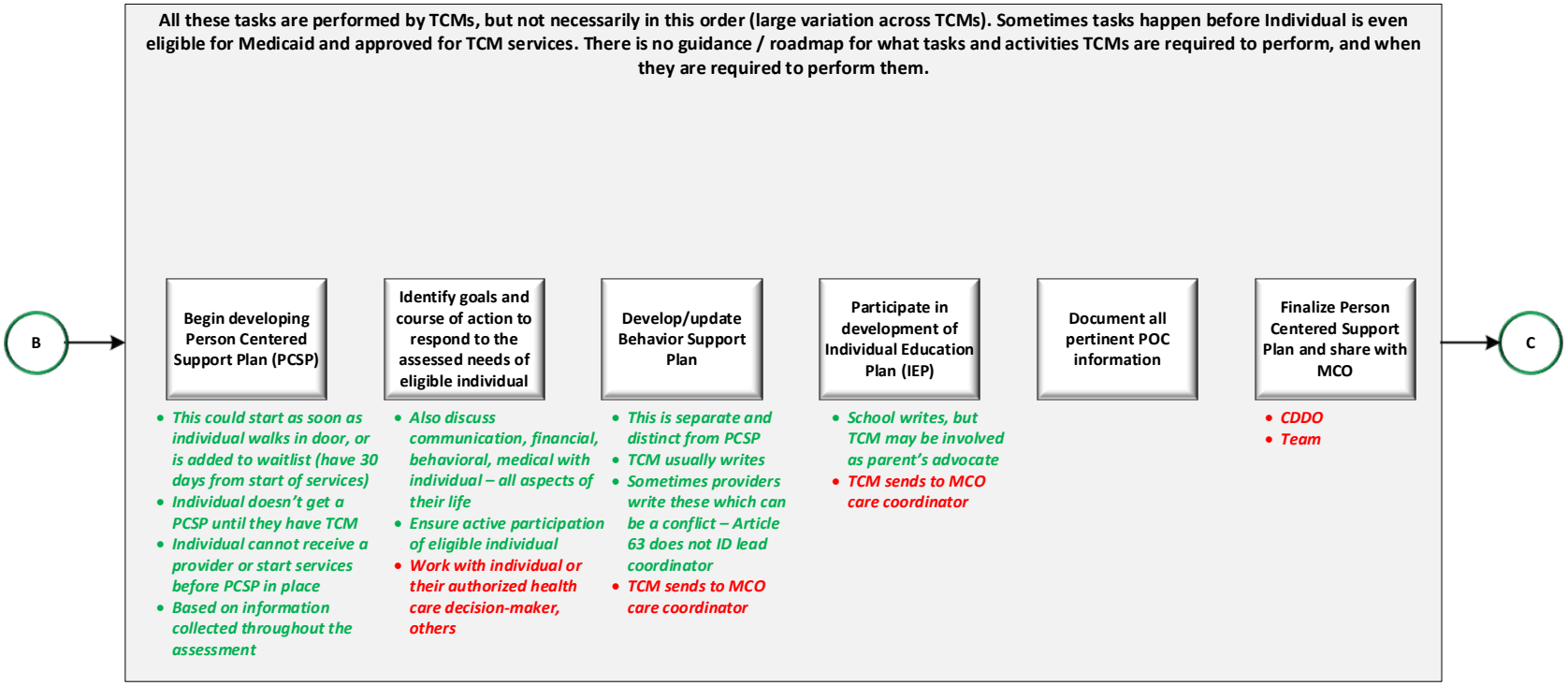
## TCM – Intake/Eligibility /Assessment



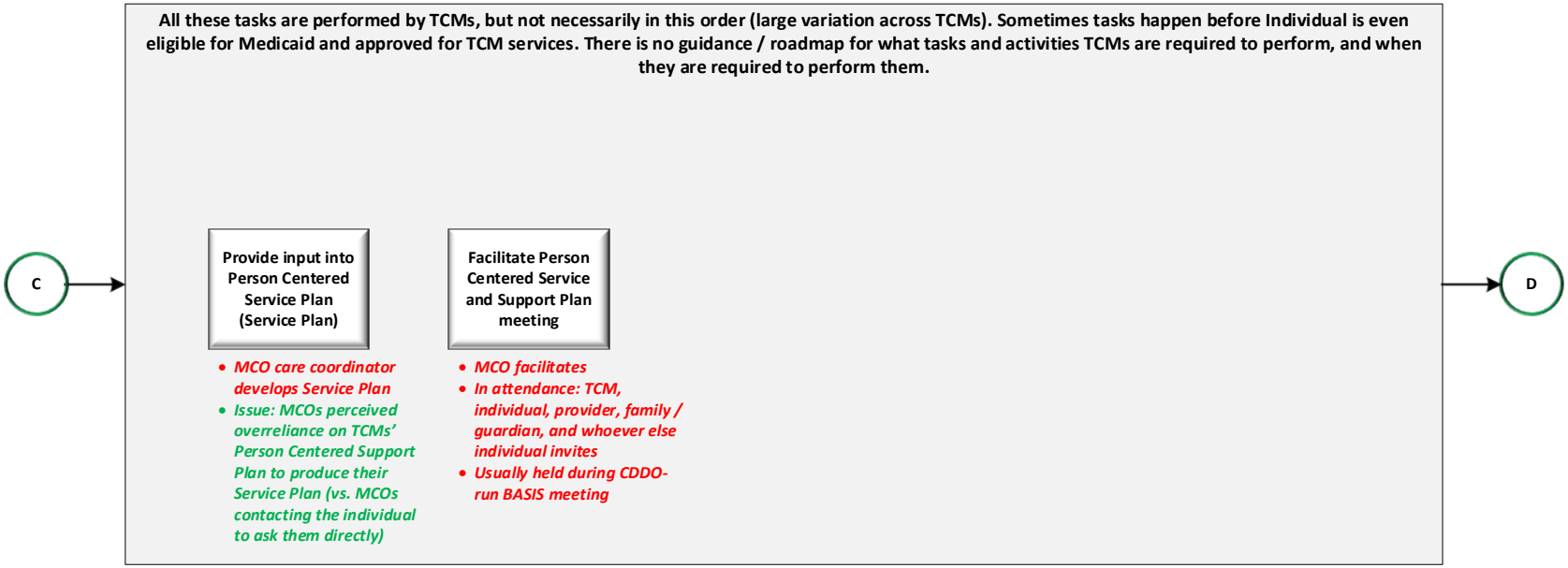
# TCM – Intake/Eligibility /Assessment



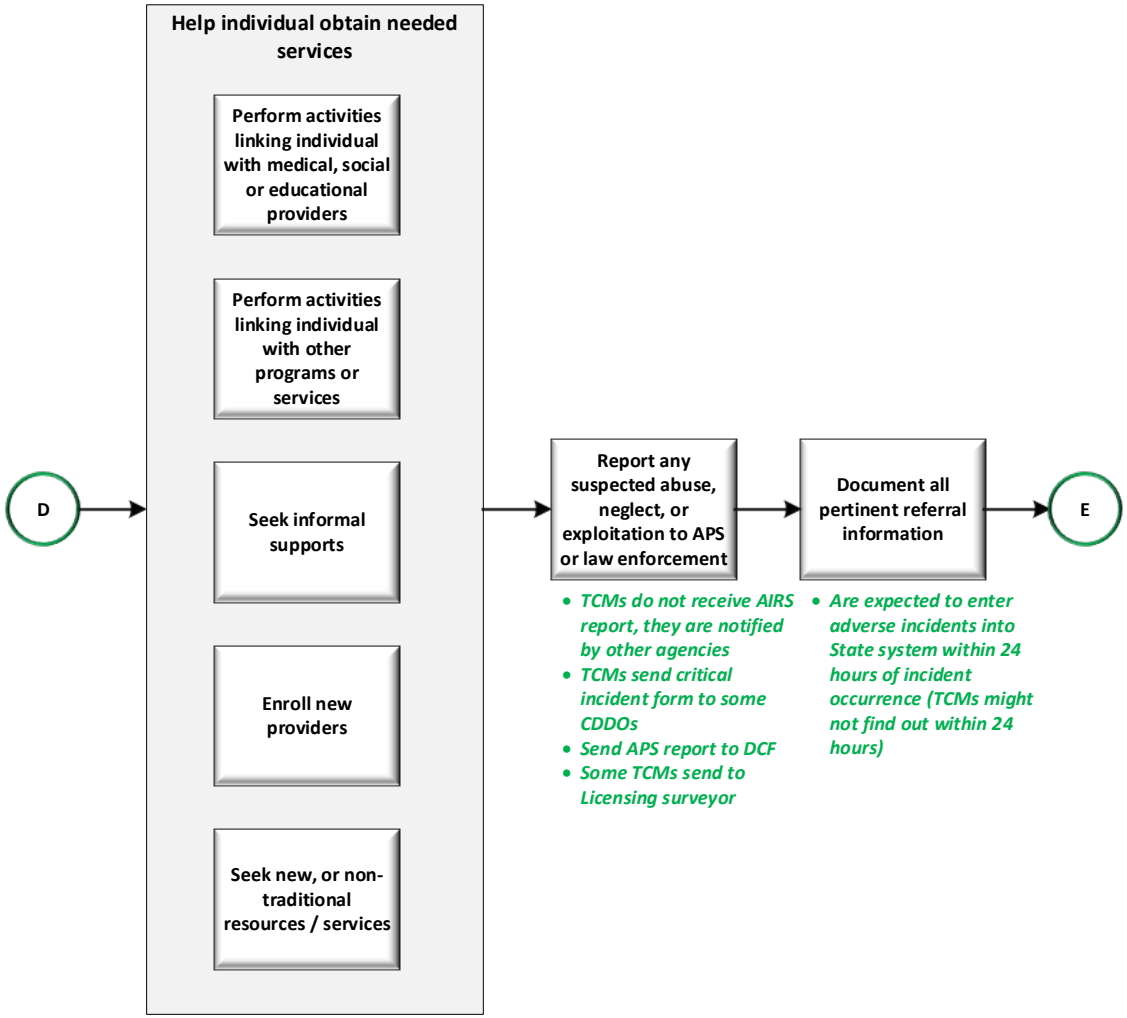
# TCM – Planning



# TCM – Planning

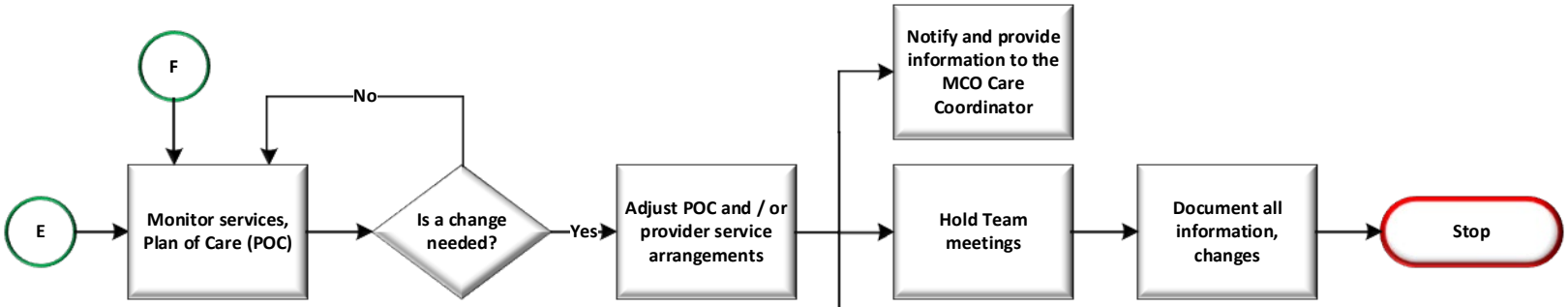


# TCM – Ongoing Services



# TCM – Ongoing Services (Monitor / QA)

- *All these steps are ongoing throughout the life of an individual's case*
- *Every case has different level of severity, needs (for example, frequency of contact with individual)*

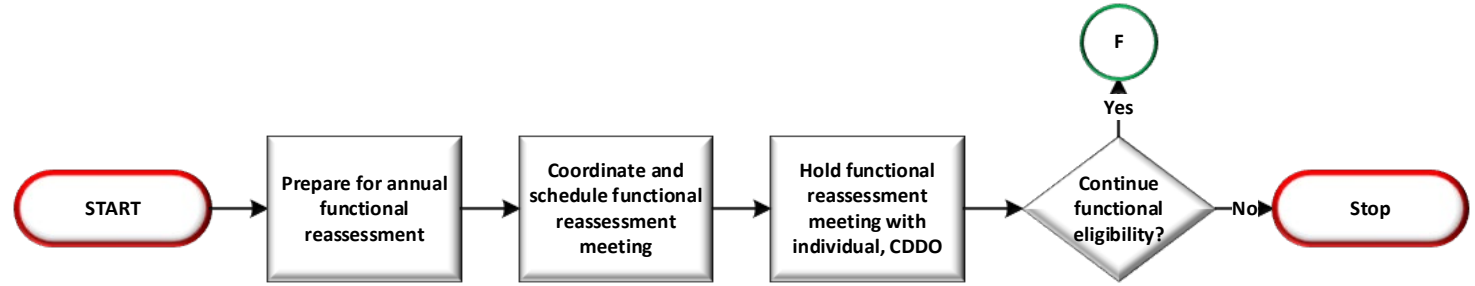



***Each TCM has different monitoring requirements, REALLY varies here, there are no state guidelines***

- *Typically, TCMs reach out quarterly, at minimum*
- *Many have monthly contact via phone, e-mail, text or face-to-face*
- *May be monitoring individuals on waitlist who may not even have a provider yet*
- *MCOs don't monitor, rely on TCMs*
- *MCO interactions with individual is more health- and services-related*

- *Are services adequate?*
- *Are services being furnished in accordance with POC?*
- *Are there changes in an individual's needs? Are there changes in an individual's status (address, guardian, etc.)*
- *TCM may receive notification of issues after KDADS, MCOs*

# TCM – Functional Reassessment




- *State is responsible for redetermining financial eligibility*
- *Prepare documents (BASIS, health assessment, etc.) for individuals receiving services*
- *Some TCMs send documents to CDDO 14 days before meeting date*
- *Schedule coordination of meeting*
- *TCM advocates for individual's needs*
- *TCMs assist with interpretation of questions (in cooperation with CDDOs) during meeting*

# TCM – Reporting

***TCM Reporting:***

- *For licensing, some TCMs 5 page quarterly checklist – for county quality oversight*
- *TCM is considered a KDHE service as TCM is paid by KDHE vs. KDADS, so they have no KDADS reporting requirements*
- *KDADS licensing department may review TCM files (falls under KDADS Article 63)*
- *CDDOs review TCM work, more so than any other entity for some TCMs*
- *QA also reviews TCM work*
- *QA of TCM files by TCM is nonbillable*

# TCM – Billing

***TCM billing:***

- *Independent TCMs complete their own billing with a maximum allowable TCM units per customer = 240 in a calendar year. (Note: TCMs can request from their MCO an increase in the 240 / year maximum allowable units.) Billing can be submitted via clearinghouse, each MCO separately, and TCMs working for a group submit to a CFO that submits all billables routinely.*
- *TCM billing is submitted monthly but TCMs may track their time on a daily basis prior to billing submission. One TCM states they submits billing weekly.*
- *There are sometimes issues with TCM-MCO billing overlap that arise from working on similar billable tasks. There should not be overlap when following defined job scopes, but outdated manuals, policies, trainings, etc. ever lead to inconsistencies and errors (e.g., billing non-billable TCM activities, TCM-MCO double billing for members enrolled in OneCare Kansas, etc.). Sometimes MCO will claim they are a duplicate service and refuse to pay, or ask for reimbursement of service.*

***Other TCM billing issues:***

- *MCO determines if something is billable or not, but there is NO clear definition of billing criteria and what TCMs have is old and expired information.*
- *Billing should be changed to a different format. Per KMAP billing, TCMs are to only keep 90 days and submission for billing contract states 120 days. So for MCO to ask for 14 months worth of information is challenging. Suggestion: move to per-day billing. For example, residential is billed x amount per day (24 hours) even if the individual only uses the service for 1 hour. Day service is billed with a max of 5 hours per day billed by the hour. Neither of these services have to have notes/logs to prove they conducted that service. Would like to see a different form of contact instead of billing in 15 minute increments. It's stressful for staff to perform the task the client needs and make sure to document it in a way that falls under the 4 pillars of service, but worded in a way that doesn't appear administrative nor duplication of service. Yet TCMs' role is administrative and repetitive as the client is in constant need of revision, applying for new services or renewal of service, ensuring the records are maintained and up-to-date, etc. TCMs are not able to bill for travel to/from a client like other CMs from other waivers.*

***Other TCM responsibilities mentioned but not discussed during process mapping session due to time constraints:***

- *Foster care system ("crisis")*
- *Psychiatric Rehab Treatment Facility (PRTF) for kids*
- *State mental health facilities*
- *Other waiver services (billed to IDD?)*

# APPENDIX D: INDIVIDUAL, FAMILY, GUARDIAN SURVEY

Q1
**Kansas Department for Aging and Disability Services – Individual and Family Survey**

The Kansas Department for Aging and Disability Services (KDADS) has asked Public Consulting Group LLC (PCG), a vendor of the state, to review the current state of Kansas' Intellectual and Developmental Disability (I/DD) Targeted Case Management (TCM) System to develop ways to follow federal government rules and to provide guidelines to improve service delivery.

**What is Care Coordination?** Care Coordination consists of services which help beneficiaries gain access to needed medical, social, educational, and other services. This includes primary care case management, which cannot be provided by a targeted case manager.

**What is Targeted Case Management?** Targeted Case Management are services aimed specifically at special groups of enrollees such as those with Intellectual/Developmental Disabilities or chronic mental illness. TCM includes four areas as identified by CMS: assessment, service plan development, referral, and monitoring.

Important information for you to know:

- Your participation in this survey is voluntary.
- You may choose not to participate.
- If you decide to participate in this survey, you may withdraw at any time.
- If at any time you do not have an answer to a question or feel uncomfortable answering, you may skip the question.
- If you decide not to participate in this survey, or if you withdraw from participating at any time, you will not be penalized.
- This survey does not affect your benefits.
- You may ask a family member or guardian to complete this survey on your behalf.

Q1 Which county do you live in?

▼ Allen County (1) ... Wyandotte County (105)

Q2 Who provides your case management?

▼ A Step Above, LLC (1) ... Other (28)

*Skip To: Q3 If Who provides your case management? = Other*

*Display This Question:*
*If Who provides your case management? = Other*

Q3 If other, please provide agency name

_____

Q4 Which agency provides your care coordination?

- ○ Aetna (1)
- ○ Sunflower Health Plan (2)
- ○ United Healthcare (3)
- ○ I am unsure (4)

Q5 In your team meetings with your care coordinator and targeted case manager are your concerns addressed?

- ○ Yes (1)
- ○ No (2)

*Skip To: Q7 If In your team meetings with your care coordinator and targeted case manager are your concerns addr... = Yes*

Q6 Please share your experience.

_____



_____

_____

_____

_____

Q7 Which agency conducts your annual assessment?

▼ Achievement Services for Northeast Kansas (1) ... I am unsure (30)

Q8 Do you feel that you have enough information about Home and Community Based Services (HCBS) waiver services?

- ○ More than necessary (1)
- ○ Its been about right (2)
- ○ Not enough (3)

*Skip To: Q9 If Do you feel that you have enough information about Home and Community Based Services (HCBS) waive... = Not enough*

*Display This Question:*

*If Do you feel that you have enough information about Home and Community Based Services (HCBS) waive... = Not enough*

Q9 Do you know where to get information or who to contact to obtain the information?

- ○ Yes (1)
- ○ No (2)



Q10 How long have you received case management services?

- ○ Not currently receiving services (1)
- ○ Less than 6 months (2)
- ○ 6 months to 1 year (3)
- ○ 1-3 years (4)
- ○ 3-5 years (5)
- ○ 5-10 years (6)
- ○ Over 10 years (7)
- ○ I am unsure (8)

Q11 Are you or your family member able to contact your targeted case manager when you want? If you call or e-mail, do they get back to you?

- ○ Always (1)
- ○ Usually (2)
- ○ Sometimes (3)
- ○ Seldom/Never (4)
- ○ I don't know (5)

---



Q12 Does your targeted case manager speak to you in a way that you can understand?

- ○ Always (1)
- ○ Usually (2)
- ○ Sometimes (3)
- ○ Seldom/Never (4)
- ○ I don't know (5)

---

Q13 Have you had any experience where you were not provided the necessary information which led to a delay in services?

- ○ Always (1)
- ○ Usually (2)
- ○ Sometimes (3)
- ○ Seldom/Never (4)
- ○ I don't know (5)



Q14 How did you first learn about HCBS waiver services?

- ○ A friend or family member (1)
- ○ A community organization (2)
- ○ A government agency (3)
- ○ Social media (4)
- ○ Health care provider (5)
- ○ Insurance provider (6)

Q15 How do you keep yourself updated with information about services, supports, and resources available in your community? Please select all that apply.

- [ ] Targeted Case Manager (1)
- [ ] Family (2)
- [ ] Friends (3)
- [ ] Service Providers (4)
- [ ] Other (please explain) (5) _____



Q16 Were you given a list of HCBS waiver providers to choose from that included all the necessary contact information?

- ○ Yes (1)
- ○ No (2)

Q17 How satisfied are you with your HCBS providers?

- ○ Very satisfied (1)
- ○ Moderately satisfied (2)
- ○ Slightly satisfied (3)
- ○ Not at all satisfied (4)

*Skip To: Q19 If How satisfied are you with your HCBS providers? = Very satisfied*
*Skip To: Q19 If How satisfied are you with your HCBS providers? = Moderately satisfied*

Q18 If slightly satisfied or not at all satisfied with your HCBS provider, please provide the names of the provider you are unsatisfied with.

_____

_____

_____

_____

_____



Q19 Do you know your rights, responsibilities, and grievance process as a participant of waiver services?

- ○ Yes (1)
- ○ No (2)

Q20 Do you work together with your targeted case manager to develop your support plan?

- ○ Yes (1)
- ○ No (2)

Q21 Have you received a copy of your support plan?

- ○ Yes (1)
- ○ No (2)

Q22 How do you prefer to receive your support plan?

- Printed plan mailed to you (1)
- Electronic plan sent to you via e-mail (2)
- SMS cell phone text (3)

Q23 The support plan is used by your targeted case manager and provider to outline the support you will receive. The support plan also helps you understand and direct your support. How useful is this support plan to you?

- Very useful (1)
- Moderately useful (2)
- Slightly useful (3)
- Not at all useful (4)

Q24 Are you receiving the services outlined in your support plan?

- Yes, all of the services (1)
- Yes, some of the services (2)
- No, none of the services (3)
- I don't know (4)

*Skip To: Q26 If Are you receiving the services outlined in your support plan? = Yes, all of the services*

*Skip To: Q26 If Are you receiving the services outlined in your support plan? = I don't know*

Q25 Please explain why you are not receiving some or all of the services outlined in you support plan.

_____

_____

_____

_____



_____

Q26 Are your HCBS waiver services provided by the same agency (or individual) that completed your support plan and that provides your case management services?

- ○ Yes (1)
- ○ No (2)
- ○ I don't know (3)

Q27 How easy was it for you to receive services?

- ○ Not easy at all (1)
- ○ Moderately easy (2)
- ○ Easy (3)
- ○ I don't know (4)

*Skip To: Q29 If How easy was it for you to receive services? = I don't know*

Q28 Please explain what made it easy or challenging for you to receive services. Were there staffing barriers, architectural barriers, medical barriers, behavioral barriers, or social determinates of health such as education, economic, or transportation barriers.

_____

_____

_____

_____

_____



Q29 What would make the process for receiving services better?

_____

_____

_____

_____

_____

Q30 Does your targeted case manager talk to you about the different community services available to you on a regular basis, or only when you are dissatisfied?

- ○ Monthly (1)
- ○ Every other Month (2)
- ○ Quarterly (3)
- ○ Annual (4)
- ○ Not at all (5)
- ○ Only when I am dissatisfied (6)
- ○ Other (Please explain) (7) _____



Q31 Do you currently have a job?

- ○ Yes (1)
- ○ No (2)

*Skip To: Q34 If Do you currently have a job? = Yes*

Q32 Would you like to have a job?

- ○ Yes (1)
- ○ No (2)

*Skip To: Q34 If Would you like to have a job? = No*

Q33 If you would like a job, have you talked to your targeted case manager about getting a job?

- ○ Yes (1)
- ○ No (2)

Q34 Is there anything else you think would be helpful for PCG to know?

_____

_____

_____

_____

_____

# APPENDIX E: COMMUNITY DEVELOPMENTAL DISABILITY ORGANIZATION SURVEY

Q00
**Kansas Department for Aging and Disability Services – Community Development Disability Organizations (CDDO)**

The Kansas Department for Aging and Disability Services (KDADS) has asked Public Consulting Group LLC (PCG), as a vendor of the state, to review the current state of Kansas' Intellectual and Developmental Disability (I/DD) Targeted Case Management (TCM) System to come into compliance with federal regulations and to provide guidelines to improve service delivery.

Important information for you to know: Your participation in this survey is voluntary. You may choose not to participate. If you decide to participate in this survey, you may withdraw at any time. If at any time you do not have an answer to a question or feel uncomfortable answering, you may skip the question. If you decide not to participate in this survey, or if you withdraw from participating at any time, you will not be penalized.

Q1 Please select your agency:

▼ Achievement Services for Northeast Kansas (1) ... Prairie Ridge (29)

---

Q2 Which role most closely represents your position?

- ○ Leadership (e.g., CEO, COO, CFO, etc.) (1)
- ○ Supervisor (2)
- ○ BASIS assessor (3)
- ○ Support staff (4)
- ○ Other (5) _____

---

Q3 Does the state or your agency provide training relevant to the work that you do?

- ○ Yes (1)
- ○ No (2)

*Skip To: Q10 If Does the state or your agency provide training relevant to the work that you do? = No*

Q4 Are the trainings you receive provided by the state or your agency?

- ○ State departments (1)
- ○ Agency (2)
- ○ Both (3)
- ○ If neither, who provides your training? (4) _____



Q5 How often is training offered through the state or your agency?

- ○ Annual (1)
- ○ Bi-annual (2)
- ○ Quarterly (3)
- ○ Monthly (4)
- ○ None of the above (5)
- ○ Other (please explain) (6) _____

Q6 Do you find the training informational and helpful?

- ○ Yes (1)
- ○ No (2)

Q10 How could training be more helpful, both in your role and to your agency?

_____

_____

_____

_____

_____



Q11 How do you help individuals obtain Home and Community Based Services (HCBS) services or other needed services?

_____

_____

_____

_____

_____

Q12 Do you have the resources and/or information necessary to help individuals select a TCM agency?

- ○ Yes (1)
- ○ No (2)

---

Q13 Who helps the individual select a TCM Agency? Please select all that apply.

- ☐ Myself (1)
- ☐ Someone else in my agency (please provide role/position) (2) _____
- ☐ MCO (3)
- ☐ Direct service provider (4)
- ☐ Individual, family, guardian, or advocate (5)
- ☐ Other (please explain) (6) _____

---

Q14 Do you coordinate with MCOs?

- ○ Yes (1)
- ○ No (2)

*Skip To: Q16 If Do you coordinate with MCOs? = No*

---

Q15 If an individual is in need, how are you as a CDDO coordinating with the MCO?

- ○ Referral for services (1)
- ○ Information sharing regarding the individual (e.g., information about service needs). Please explain. (2) _____
- ○ Other (please explain) (3) _____

Q16 Do you coordinate with the TCM agency once an individual is receiving services?



- ○ Yes (1)
- ○ No (2)

*Skip To: Q18 If Do you coordinate with the TCM agency once an individual is receiving services? = No*

Q17 What situations necessitate coordination with the TCM agency?

- ○ Reassessment for eligibility and/or support needs (1)
- ○ Referral for services (2)
- ○ Information sharing regarding the individual (e.g., information about service needs). Please explain. (3)
- ○ Other (please explain) (4) _____

Q18 Are you responsible for TCM quality assurance activities?

- ○ Yes (1)
- ○ No (2)

*Skip To: Q22 If Are you responsible for TCM quality assurance activities? = No*

Q19 What quality assurance activities do you perform? Please select all that apply.

- ☐ Data collection (1)
- ☐ Data analysis (2)
- ☐ Plans of correction issuance (3)
- ☐ Reporting to KDADS (4)
- ☐ Reporting to the MCO (5)
- ☐ Oversight of rights restrictions (6)
- ☐ ANE AIRS Reports (7)
- ☐ Other (please explain) (8) _____



Q20 Do you have the tools, technology and resources necessary to perform quality assurance activities?

- ○ Yes (1)
- ○ No (2)

Q21 What additional tools and resources would help you perform quality assurance activities?

_____

_____

_____

_____

_____



Q22 Is there anything else you think would be helpful for PCG to know?

_____

_____

_____

_____

_____

# APPENDIX F: MANAGED CARE ORGANIZATION SURVEY

Q1
**Kansas Department for Aging and Disability Services – Managed Care Organization (MCO)**

The Kansas Department for Aging and Disability Services (KDADS) has asked Public Consulting Group LLC (PCG), as a vendor of the state, to review the current state of Kansas' Intellectual and Developmental Disability (I/DD) Targeted Case Management (TCM) System to come into compliance with federal regulations and to provide guidelines to improve service delivery.

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- If you decide to participate in this survey, you may withdraw at any time.
- If at any time you do not have an answer to a question or feel uncomfortable answering, you may skip the question.
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Q1 Please select your agency:

- ○ Aetna (1)
- ○ Sunflower Health Plans (2)
- ○ United Healthcare (3)

Q2 What role most closely represents your position?

- ○ Manager (1)
- ○ Supervisor (2)
- ○ Care Coordinator (3)
- ○ Support Staff (4)
- ○ Other (please provide role) (5) _____



Q3 Does your agency contract the development and monitoring of the person-centered service plan?

- ○ Yes (1)
- ○ No (2)

*Skip To: Q5 If Does your agency contract the development and monitoring of the person-centered service plan? = No*

Q4 What are the names of all the agencies (contracted entities) that you contract with to develop the person-centered service plans?

_____

_____

_____

_____

_____

Q5 What is the average caseload size for care coordinators?

- ○ 0-20 (1)
- ○ 21-40 (2)
- ○ 41-60 (3)
- ○ 61-80 (4)
- ○ 81-100 (5)
- ○ 101+ (6)



Q6 6. Who provides the training relevant to your job responsibilities?

- ○ State Departments (1)
- ○ Agency (2)
- ○ Both (3)
- ○ Neither (Please provide who if none of the above) (4) _____

Q7 How often is training offered through the state or your agency?

- ○ Annually (1)
- ○ Bi-Annually (2)
- ○ Quarterly (3)
- ○ Monthly (4)
- ○ I do not receive training (5)
- ○ Other (Please explain) (6) _____

*Skip To: Q10 If How often is training offered through the state or your agency? = I do not receive training*

Q8 Do you find the training informational and helpful with regards to your assigned tasks?

- ○ Yes (1)
- ○ No (2)

*Skip To: Q10 If Do you find the training informational and helpful with regards to your assigned tasks? = Yes*

Q9 How could training be more helpful, both in your role and to your agency?

_____

_____

_____

_____

Q10 Do you coordinate with the Targeted Case Manager to make sure both support plans and person-centered service plans have coordinated goals and objectives?

- ○ Yes (1)
- ○ No (2)

*Skip To: Q13 If Do you coordinate with the Targeted Case Manager to make sure both support plans and person-cente... = No*

Q11 How do you coordinate with the Targeted Case Manager? Please select all that apply.

- ☐ In person meetings with the individual (1)
- ☐ Over the phone (2)
- ☐ Targeted Case Manager participation in service plan meetings (3)
- ☐ Via email (4)
- ☐ Other (please explain) (5) _____

Q12 Do you find that the Targeted Case Manager is accessible (for coordinating purposes)?

- ○ Yes (1)
- ○ No (please explain) (2) _____

Q13 Would better coordination between you and the Targeted Case Manager improve service delivery for those who are receiving or seeking services?

- ○ Yes (1)
- ○ No (2)

Q14 Do you help educate individuals so they can make informed choices when choosing their service provider?

- ○ Yes (1)
- ○ No (2)



*Skip To: Q17 If Do you help educate individuals so they can make informed choices when choosing their service pro... = No*

*Skip To: Q15 If Do you help educate individuals so they can make informed choices when choosing their service pro... = Yes*

Q15 How do you inform individuals of available service providers? Please select all that apply.

- ☐ Provide a list of service providers in the area (1)
- ☐ Recommend providers based on the services needed (2)
- ☐ Recommend your favorite providers/providers based on past experiences (3)
- ☐ Other (Please explain) (4) _____

Q16 How does your agency determine the needs, frequency, and duration of services for eligible individuals?

Q17 Is there anything else you think would be helpful for PCG to know?

# APPENDIX X: COMMUNITY SERVICE PROVIDER SURVEY

Q1
**Kansas Department for Aging and Disability Services – HCBS Provider Survey**

The Kansas Department for Aging and Disability Services (KDADS) has asked Public Consulting Group LLC (PCG), as a vendor of the state, to review the current state of Kansas' Intellectual and Developmental Disability (I/DD) Targeted Case Management (TCM) System to come into compliance with federal regulations and to provide guidelines to improve service delivery.

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- If you decide not to participate in this survey, or if you withdraw from participating at any time, you will not be penalized.

Q2 What is your agency's name?

_____

Q3 What Home and Community Based Services (HCBS) waivers do you serve? Please select all that apply.

- [ ] Physical Disability (PD) Waiver (1)
- [ ] Frail Elderly (FE) Waiver (2)
- [ ] Brain Injury (BI) Waiver (3) DRAFT
- [ ] Autism (AU) Waiver (4)
- [ ] Intellectual/Developmental Disability (I/DD) Waiver (5)
- [ ] Serious Emotional Disturbance (SED) Waiver (6)
- [ ] Technology Assisted (TA) Waiver (7)

Q4 Would you be open to providing services for other waivers?

- ○ Yes (1)
- ○ No (2)

*Skip To: Q6 If Would you be open to providing services for other waivers? = No*

Q5 What waivers would you be interested in serving? Please select all that apply.

- ☐ Physical Disability (PD) Waiver (1)
- ☐ Frail Elderly (FE) Waiver (2)
- ☐ Brain Injury (BI) Waiver (3)
- ☐ Autism (AU) Waiver (4)
- ☐ Intellectual/Developmental Disability (I/DD) Waiver (5)
- ☐ Serious Emotional Disturbance (SED) Waiver (6)
- ☐ Technology Assisted (TA) Waiver (7)

---

Q6 What has prevented you from expanding services to another waiver? Please select all that apply.

- ☐ Unfamiliar with the population served (1)
- ☐ Lack of training (2)
- ☐ Lack of staff (3)
- ☐ Other (4) _____

---

Q7 Which counties do you currently serve? Please select all that apply.

- [ ] Allen County (1)
- [ ] Anderson County (2)
- [ ] Atchison County (3)
- [ ] Barber County (4)
- [ ] Barton County (5)
- [ ] Bourbon County (6)
- [ ] Brown County (7)
- [ ] Butler County (8)
- [ ] Chase County (9)
- [ ] Chautauqua County (10)
- [ ] Cherokee County (11)
- [ ] Cheyenne County (12)
- [ ] Clark County (13)
- [ ] Clay County (14)
- [ ] Cloud County (15)
- [ ] Coffey County (16)
- [ ] Comanche County (17)

- [ ] Cowley County (18)
- [ ] Crawford County (19)
- [ ] Decatur County (20)
- [ ] Dickinson County (21)
- [ ] Doniphan County (22)
- [ ] Douglas County (23)
- [ ] Edwards County (24)
- [ ] Elk County (25)
- [ ] Ellis County (26)
- [ ] Ellsworth County (27)
- [ ] Finney County (28)
- [ ] Ford County (29)
- [ ] Franklin County (30)
- [ ] Geary County (31)
- [ ] Gove County (32)
- [ ] Graham County (33)
- [ ] Grant County (34)

- [ ] Gray County (35)
- [ ] Greeley County (36)
- [ ] Greenwood County (37)
- [ ] Hamilton County (38)
- [ ] Harper County (39)
- [ ] Harvey County (40)
- [ ] Haskell County (41)
- [ ] Hodgeman County (42)
- [ ] Jackson County (43)
- [ ] Jefferson County (44)
- [ ] Jewell County (45)
- [ ] Johnson County (46)
- [ ] Kearny County (47)
- [ ] Kingman County (48)
- [ ] Kiowa County (49)
- [ ] Labette County (50)
- [ ] Lane County (51)

- [ ] Leavenworth County (52)
- [ ] Lincoln County (53)
- [ ] Linn County (54)
- [ ] Logan County (55)
- [ ] Lyon County (56)
- [ ] Marion County (57)
- [ ] Marshall County (58)
- [ ] McPherson County (59)
- [ ] Meade County (60)
- [ ] Miami County (61)
- [ ] Mitchell County (62)
- [ ] Montgomery County (63)
- [ ] Morris County (64)
- [ ] Morton Count (65)
- [ ] Nemaha County (66)
- [ ] Neosho County (67)
- [ ] Ness County (68)

- [ ] Norton County (69)
- [ ] Osage County (70)
- [ ] Osborne County (71)
- [ ] Ottawa County (72)
- [ ] Pawnee County (73)
- [ ] Phillips County (74)
- [ ] Pottawatomie County (75)
- [ ] Pratt County (76)
- [ ] Rawlins County (77)
- [ ] Reno County (78)
- [ ] Republic County (79)
- [ ] Rice County (80)
- [ ] Riley County (81)
- [ ] Rooks County (82)
- [ ] Rush County (83)
- [ ] Russell County (84)
- [ ] Saline County (85)

- [ ] Scott County (86)
- [ ] Sedgwick County (87)
- [ ] Seward County (88)
- [ ] Shawnee County (89)
- [ ] Sheridan County (90)
- [ ] Sherman County (91)
- [ ] Smith County (92)
- [ ] Stafford County (93)
- [ ] Stanton County (94)
- [ ] Stevens County (95)
- [ ] Sumner County (96)
- [ ] Thomas County (97)
- [ ] Trego County (98)
- [ ] Wabaunsee County (99)
- [ ] Wallace County (100)
- [ ] Washington County (101)
- [ ] Wichita County (102)

- [ ] Wilson County (103)
- [ ] Woodson County (104)
- [ ] Wyandotte County (105)

---

Q8 What services can your agency bill under Medicaid? Please select all that apply.

- [ ] Respite Care (1)
- [ ] Financial Management Services (2)
- [ ] Family Adjustment Counseling (3)
- [ ] Parent Support and Training (peer to peer) Provider (4)
- [ ] Personal Care (5)
- [ ] Occupational Therapy (6)
- [ ] Physical Therapy (7)
- [ ] Speech and Language Therapy (8)
- [ ] Financial Management Services (9)
- [ ] Assistive Services (10)
- [ ] Behavior Therapy (11)
- [ ] Cognitive Rehabilitation (12)
- [ ] Enhanced Care Services (13)
- [ ] Home-Delivered Meals Services (14)
- [ ] Medication Reminder Services (15)
- [ ] Personal Emergency Response System and Installation (16)
- [ ] Transitional Living Services (17)

- [ ] Financial Management System (18)
- [ ] Adult Day Care (19)
- [ ] Assistive Services (20)
- [ ] Comprehensive Support (21)
- [ ] Enhanced Care Services (22)
- [ ] Home Telehealth (23)
- [ ] Medication Reminder Service/Installation (24)
- [ ] Nursing Evaluation Visit (25)
- [ ] Oral Health Services (26)
- [ ] Personal Care Services (27)
- [ ] Personal Emergency Response System and Installation (28)
- [ ] Wellness Monitoring (29)
- [ ] Day Supports (30)
- [ ] Overnight Respite Care (31)
- [ ] Personal Care Services (32)
- [ ] Residential Supports (33)
- [ ] Supported Employment (34)

- [ ] Financial Management Services (FMS) (35)
- [ ] Assistive Services (36)
- [ ] Enhanced Care Services (37)
- [ ] Medical Alert Rental (38)
- [ ] Specialized Medical Care (39)
- [ ] Wellness Monitoring (40)
- [ ] Personal Care Services (41)
- [ ] Financial Management Services (42)
- [ ] Assistive Services (43)
- [ ] Enhanced Care Services (44)
- [ ] Home- Delivered Meals Services (45)
- [ ] Medication Reminder Services (46)
- [ ] Personal Emergency Response System and Installation (47)
- [ ] Attendant Care (48)
- [ ] Independent Living/ Skills Building (49)
- [ ] Short-Term Respite Care (50)
- [ ] Parent Supporting and Training (51)

- ☐ Professional Resource Family Care (52)
- ☐ Wraparound Facilitation (53)
- ☐ Medical Respite Care (54)
- ☐ Personal Care Services (55)
- ☐ Financial Management Services (56)
- ☐ Health Maintenance (57)
- ☐ Home Modification (58)
- ☐ Intermittent Intensive Medical Care (59)
- ☐ Specialized Medical Care (60)
- ☐ Please list waiver and services provided (61)

_____

- ☐ Please list waiver and services provided (62)

_____

- ☐ Please list waiver and services provided (63)

_____

- ☐ Please list waiver and services provided (64)

_____

Q9 Does your agency have a waitlist for services?

- ○ Yes (1)
- ○ No (2)

*Skip To: Q13 If Does your agency have a waitlist for services? = No*

Q10 What is the cause of the waitlist?

- ○ Unable to staff participant needs or schedule (1)
- ○ Unable to recruit and/or retain staff (2)
- ○ Number of referrals received at one time (3)
- ○ Limited space (4)
- ○ Other (5) _____

Q11 What are you doing to eliminate the waitlist?

_____

_____

_____

_____

_____

Q12 What supports could you use to help eliminate the waitlist?

_____

_____

_____

_____

_____

Q13 How do individuals seeking HCBS waiver services know you have the availability to provide services?

_____

_____



_____

_____

_____

Q14 How do you receive referrals to your agency? Please select all that apply.

- ☐ CDDO (1)
- ☐ MCO (2)
- ☐ TCM (3)
- ☐ Other (4) _____

Q15 What happens when an individual is unsatisfied with their services? Please select all that apply.

- ☐ Find a new staff person to provide services (1)
- ☐ Discuss the situation with the dissatisfied individual (2)
- ☐ Contact the TCM agency (3)
- ☐ Have a team meeting (4)
- ☐ Other (5) _____



Q16 How do you Assist individuals to transition to a new or different provider?

_____

_____

_____

_____

_____

Q17 What are some of the barriers your agency has experienced with providing services to individuals? Please select all that apply.

- ☐ Lack of knowledge of populations served (1)
- ☐ Lack of understanding about how to engage individuals served (2)
- ☐ Limited knowledge about services or resources available (3)
- ☐ Limited time with individuals (4)
- ☐ Lack of financial resources (5)
- ☐ None (6)

Q18 What could help improve services for individuals accessing HCBS? Please select all that apply.

- ☐ More education and training (1)
- ☐ Greater public awareness (2)
- ☐ More providers (3)
- ☐ More support options (4)
- ☐ Financial assistance (5)
- ☐ Peer support (6)
- ☐ Transportation (7)
- ☐ Hours of operation (8)
- ☐ Other (9) _____



Q19 Is there anything else you think would be helpful for PCG to know?

_____

# APPENDIX G: TARGETED CASE MANAGER SURVEY

Q1
**Kansas Department for Aging and Disability Services – Targeted Case Management**

The Kansas Department for Aging and Disability Services (KDADS) has asked Public Consulting Group LLC (PCG), as a vendor of the state, to review the current state of Kansas' Intellectual and Developmental Disability (I/

DD) Targeted Case Management (TCM) System to come into compliance with federal waiver regulations and guidelines and improve service delivery.

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- If you decide to participate in this survey, you may withdraw at any time.
- If at any time you do not have an answer to a question or feel uncomfortable answering, you may skip the question.
- If you decide not to participate in this survey, or if you withdraw from participating at any time, you will not be penalized.



Q1 Please select your agency:

▼ A Step Above, LLC (1) ... Other (27)

*Skip To: Q2 If Please select your agency: = Other*

*Display This Question:*
*If Please select your agency: = Other*

Q2 If Other, please provide agency name

_____

Q3 Please select what best describes your agency

- ○ Independent targeted case manager (no agency, single staff member) (1)
- ○ Targeted case management agency (more than one staff member/employee, does not provide any other services) (2)
- ○ Service agency (provides direct HCBS waiver services and Targeted Case Management) (3)
- ○ Other (Please describe) (4) _____

Q4 Which Counties do you serve? Please select all that apply.

- [ ] Allen County (1)
- [ ] Anderson County (2)
- [ ] Atchison County (3)
- [ ] Barber County (4)
- [ ] Barton County (5)
- [ ] Bourbon County (6)
- [ ] Brown County (7)
- [ ] Butler County (8)
- [ ] Chase County (9)
- [ ] Chautauqua County (10)
- [ ] Cherokee County (11)
- [ ] Cheyenne County (12)
- [ ] Clark County (13)
- [ ] Clay County (14)
- [ ] Cloud County (15)
- [ ] Coffey County (16)

- [ ] Comanche County (17)
- [ ] Cowley County (18)
- [ ] Crawford County (19)
- [ ] Decatur County (20)
- [ ] Dickinson County (21)
- [ ] Doniphan County (22)
- [ ] Douglas County (23)
- [ ] Edwards County (24)
- [ ] Elk County (25)
- [ ] Ellis County (26)
- [ ] Ellsworth County (27)
- [ ] Finney County (28)
- [ ] Ford County (29)
- [ ] Franklin County (30)
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- [ ] Graham County (33)

- [ ] Grant County (34)
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- [ ] Hamilton County (38)
- [ ] Harper County (39)
- [ ] Harvey County (40)
- [ ] Haskell County (41)
- [ ] Hodgeman County (42)
- [ ] Jackson County (43)
- [ ] Jefferson County (44)
- [ ] Jewell County (45)
- [ ] Johnson County (46)
- [ ] Kearny County (47)
- [ ] Kingman County (48)
- [ ] Kiowa County (49)
- [ ] Labutte County (50)

- [ ] Lane County (51)
- [ ] Leavenworth County (52)
- [ ] Lincoln County (53)
- [ ] Linn County (54)
- [ ] Logan County (55)
- [ ] Lyon County (56)
- [ ] Marion County (57)
- [ ] Marshall County (58)
- [ ] McPherson County (59)
- [ ] Meade County (60)
- [ ] Miami County (61)
- [ ] Mitchell County (62)
- [ ] Montgomery County (63)
- [ ] Morris County (64)
- [ ] Morton County (65)
- [ ] Nemaha County (66)
- [ ] Neosho County (67)

- [ ] Ness County (68)
- [ ] Norton County (69)
- [ ] Osage County (70)
- [ ] Osborne County (71)
- [ ] Ottawa County (72)
- [ ] Pawnee County (73)
- [ ] Phillips County (74)
- [ ] Pottawatomie County (75)
- [ ] Pratt County (76)
- [ ] Rawlins County (77)
- [ ] Reno County (78)
- [ ] Republic County (79)
- [ ] Rice County (80)
- [ ] Riley County (81)
- [ ] Rooks County (82)
- [ ] Rush County (83)
- [ ] Russell County (84)

- [ ] Saline County (85)
- [ ] Scott County (86)
- [ ] Sedgwick County (87)
- [ ] Seward County (88)
- [ ] Shawnee County (89)
- [ ] Sheridan County (90)
- [ ] Sherman County (91)
- [ ] Smith County (92)
- [ ] Stafford County (93)
- [ ] Stanton County (94)
- [ ] Stevens County (95)
- [ ] Sumner County (96)
- [ ] Thomas County (97)
- [ ] Trego County (98)
- [ ] Wabaunsee County (99)
- [ ] Wallace (100)
- [ ] Washington County (101)

- [ ] Wichita County (102)
- [ ] Wilson County (103)
- [ ] Woodson County (104)
- [ ] Wyandotte County (105)

---

Q5 If you are a service agency, what Home and Community Based Services (HCBS) waiver services do you provide/support? Please select all that apply.

- [ ] Day Supports (1)
- [ ] Overnight Respite Care (2)
- [ ] Personal Care Services (3)
- [ ] Residential Supports (4)
- [ ] Supported Employment (5)
- [ ] Financial Management Services (6)
- [ ] Assistive Services (7)
- [ ] Enhanced Care Services (8)
- [ ] Medical Alert Rental (9)
- [ ] Specialized Medical Care (10)
- [ ] Wellness Monitoring (11)

Q6 What role most closely represents your position?

- ○ Manager (1)
- ○ Supervisor (2)
- ○ Targeted Case Manager (3)
- ○ Support Staff (4)
- ○ Other (Please provide role) (5) _____



Q7 Do any providers (including your agency) that you work with have a waitlist for services?

- ○ Yes (1)
- ○ No (2)

Q8 What are the most common services that have waitlists or are difficult to find a provider for?

- [ ] Day Supports (1)
- [ ] Overnight Respite Care (2)
- [ ] Personal Care Services (3)
- [ ] Residential Supports (4)
- [ ] Supported Employment (5)
- [ ] Financial Management Services (6)
- [ ] Assistive Services (7)
- [ ] Enhanced Care Services (8)
- [ ] Medical Alert Rental (9)
- [ ] Specialized Medical Care (10)
- [ ] Wellness Monitoring (11)
- [ ] Other (Please provide name of service) (12) _____

Q9 What is your average caseload size for targeted case managers?

- 0-20 (1)
- 21-40 (2)
- 41-60 (3)
- 61-80 (4)
- 81-100 (5)
- 101+ (6)



Q10 How do you conduct annual person-centered support plan development?

- In person (1)
- Virtually (2)
- Other (please explain) (3) _____

Q11 In a typical support plan year, how often do you meet **in person** with individuals for whom you provide case management services ***prior*** to the end of the Public Health Emergency May 2023?

- Once monthly (1)
- Quarterly (2)
- Bi-annually (3)
- Annually (4)

Q12 In a typical support plan year, how often do you meet **virtually** with individuals for whom you provide case management services ***prior*** to the end of the Public Health Emergency May 2023?

- ○ Once monthly (1)
- ○ Quarterly (2)
- ○ Bi-Annually (3)
- ○ Annually (4)



Q13 In a typical support plan year, how often do you meet **in person** with individuals for whom you provide case management services ***after*** the end of the Public Health Emergency May 2023?

- ○ Once monthly (1)
- ○ Quarterly (2)
- ○ Bi-annually (3)
- ○ Annually (4)

Q14 In a typical support plan year, how often do you meet **virtually** with individuals for whom you provide case management services ***after*** the end of the Public Health Emergency May 2023?

- ○ Once Monthly (1)
- ○ Quarterly (2)
- ○ Bi-annually (3)
- ○ Annually (4)

---



Q15 On average, how many roundtrip miles do you drive for an in person meeting with an individual?

- ○ 1-10 Miles (1)
- ○ 11-20 Miles (2)
- ○ 21-30 Miles (3)
- ○ 31-40 Miles (4)
- ○ 41-50 Miles (5)
- ○ More than 50 Miles (6)

---

Q16 On average, how many minutes do you spend driving to/from an in person meeting with an individual (per trip)?

- 1-10 Minutes (1)
- 11-20 Minutes (2)
- 21-30 Minutes (3)
- 31-40 Minutes (4)
- 41-50 Minutes (5)
- 51-60 Minutes (6)
- 61+ Minutes (7)



Q17 Do you educate individuals on their available waiver services?

- Yes (1)
- No (2)

Q18 Do you have the tools/Information necessary to help educate individuals to select providers?

- Yes (1)
- No (2)

*Skip To: Q20 If Do you have the tools/Information necessary to help educate individuals to select providers? = Yes*

Q19 What additional tools/information do you need, if any, to help educate individuals to select providers?

_____

Q20 What other services are you aware of to support individuals beyond those provided under the HCBS waiver? Please select all that apply.

- ☐ State Plan benefits (doctors, prescriptions, etc.) (1)
- ☐ Employment supports through Vocational Rehabilitation(or other agencies) (2)
- ☐ Community Mental Health Centers (3)
- ☐ Community resources (4)
- ☐ Other (please explain) (5) _____



Q21 Does the state or your agency provide training relevant to the work that you do?

- ○ Yes (1)
- ○ No (2)

*Skip To: Q26 If Does the state or your agency provide training relevant to the work that you do? = No*

Q23 Are the trainings you receive provided by the state or your agency?

- ○ State Departments (1)
- ○ Agency (2)
- ○ Both (3)
- ○ If neither, who provides your training? (4) _____

---

Q24 Do you find the training informational and helpful?



- ○ Yes (1)
- ○ No (2)

---

Q25 How often is training offered through the state or your agency?

- ○ Initially (1)
- ○ Annually (2)
- ○ Bi-annually (3)
- ○ Quarterly (4)
- ○ Monthly (5)
- ○ None of the above (6)
- ○ Other (please explain) (7) _____

---

*Display This Question:*

*If Does the state or your agency provide training relevant to the work that you do? = No*

Q26 How could training improve your service delivery to individuals?

_____

_____

_____

_____

_____



Q27 Does the CDDO provide information meetings to update Targeted Case Managers on policy, statute, regulation changes, upcoming initiatives, etc.?

- Yes (1)
- No (2)

*Display This Question:*

*If Does the CDDO provide information meetings to update Targeted Case Managers on policy, statute, r... = Yes*

Q28 How does the CDDO inform you of these informational meetings? Please select all that apply.

- [ ] State Website (1)
- [ ] Informational memo (2)
- [ ] Meetings (3)
- [ ] Agency Leadership (4)
- [ ] Other (please explain) (5) _____



Q29 How are you informed of policy changes? Please select all that apply.

- [ ] State website (1)
- [ ] Informational memo (2)
- [ ] Meetings (3)
- [ ] Agency leadership (4)
- [ ] Other (please explain) (5) _____

Q30 Do you coordinate with the Managed Care Organization (MCO) to make sure both needs assessment, level of care, support plan, and person centered service plans have coordinated goals and objectives?

- ○ Yes (1)
- ○ No (2)

*Skip To: Q34 If Do you coordinate with the Managed Care Organization (MCO) to make sure both needs assessment, le... = No*

Q31 How do you coordinate with the MCO?



- ○ In person meetings with the individual (1)
- ○ Over the phone (2)
- ○ Via email (3)
- ○ MCO participation in support plan meetings (4)
- ○ Other (please explain) (5) _____

Q32 Is coordinating with the MCO seamless?

- ○ Yes (1)
- ○ No (2)

*Skip To: Q35 If Is coordinating with the MCO seamless? = Yes*

Q33 Would you recommend any areas of opportunity for MCO and TCM coordination and collaboration?

_____

_____

_____

_____

_____

Q34 Would better coordination between you and the MCO improve service delivery for those who are receiving or seeking services?

- Yes (1)
- No (2)



Q35 Who is responsible for billing Targeted Case Management services at your agency?

- Myself (1)
- My supervisor (2)
- Finance office/team (3)
- Other (Please explain) (4) _____

*Skip To: Q42 If Who is responsible for billing Targeted Case Management services at your agency? != Myself*

Q36 How often do you bill for Targeted Case Management Services?

- ○ Weekly (1)
- ○ Every other week (2)
- ○ Monthly (3)
- ○ Every other month (4)
- ○ Quarterly (5)
- ○ Unsure (6)
- ○ Other (Please provide frequency) (7) DRAFT _____

Q37 Do you have the tools/resources necessary to bill for Targeted Case Management Services?

- ○ Yes (1)
- ○ No (please provided needed tools/resources/other supports) (2) _____

Q38 Please list any inefficient and/or duplicative billing tasks

_____

_____

_____

_____

_____

Q39 How many individuals require more than 240 units of Targeted Case Management in a support plan year?

- ○ None (1)
- ○ 1-5 (2)
- ○ 6-10 (3)
- ○ 11-20 (4)
- ○ 21-30 (5)
- ○ More than 30 (6)



Q40 Why would an individual require more than 240 units of Targeted Case Management in a support plan year? Please select all that apply.

- ☐ Frequent changing of providers (1)
- ☐ Critical incidents/crises (2)
- ☐ Change in support needs (3)
- ☐ Change in or lack of natural supports (4)
- ☐ Other (Please explain) (5) _____

Q41 Are there any tasks you regularly perform that are not billable?

- ○ Yes (please explain explain non-billable tasks) (1) _____
- ○ No (2)

Q42 Is there anything else you think would be helpful for PCG to know?

_____

_____



_____

_____

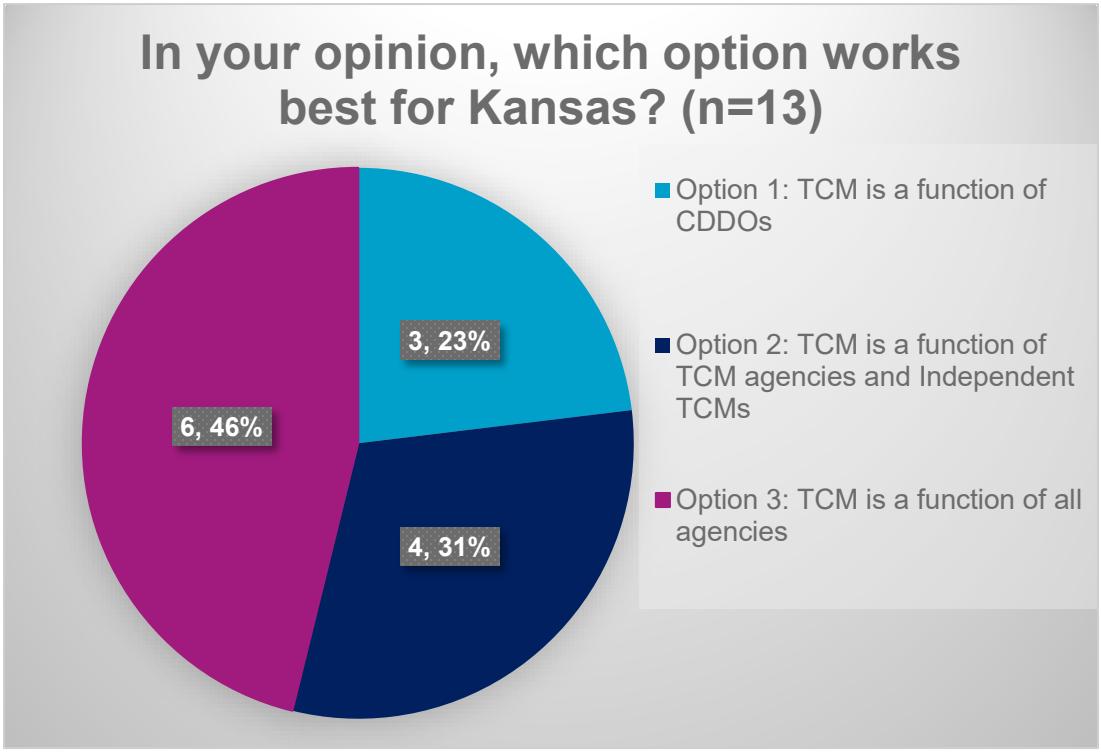
_____

# APPENDIX H: OPTIONS STAKEHOLDER FEEDBACK

Stakeholders were able to complete a virtual survey to express their opinions on the compliance options presented in this report. 20 total respondents submitted surveys. Questions were not required to be completed, so the total number of respondents for each question is indicated in the titles of the survey results graphs.

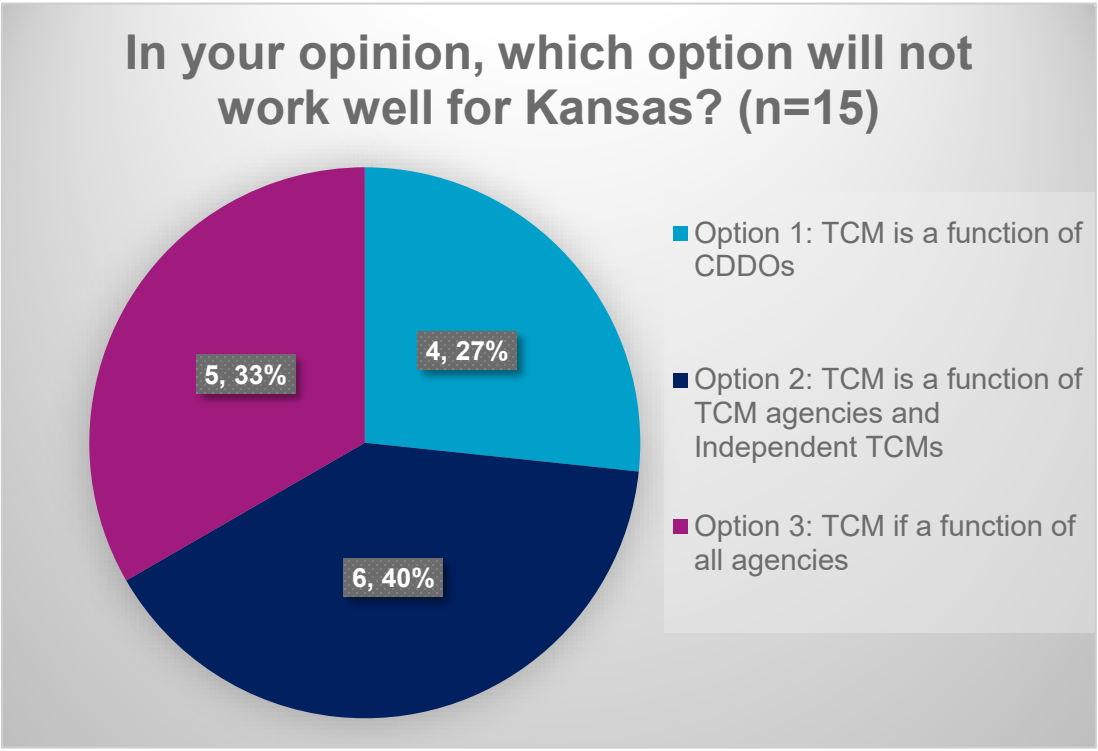
Out of 13 responses, 46% (6 responses) indicated Option 3 (TCM is a function of all agencies) as the option that would work best for Kansas.

FIGURE 14: WHICH OPTION WORKS BEST FOR KANSAS



Survey respondents were also asked to identify which of the compliance options they felt would not work well for Kansas. Out of 15 responses, 40% indicated Option 2 (TCM is a function of TCM agencies and Independent TCMs) would not work well for Kansas.

FIGURE 15: WHICH OPTION WILL NOT WORK WELL FOR KANSAS




The survey also included free response sections for respondents to share their opinions and perspectives on the options. The common themes from these responses are presented below.

## OPTION 1: FREE RESPONSE

### Benefits

- CDDOs could hire current CSP TCMs as TCMs so they wouldn't have to start independent agency
- Safety net is a benefit

### Things to Consider

- How many individuals will be affected?
- CDDOs would need time and support to do this
- Rural areas would need technical assistance
- CDDOs vary in quality and ability to provide services
- How would CDDOs provide QA over their in-house TCM?
- Monthly billable encounter rate

### Concerns

- Concern that if CDDOs are more than a safety net choice for TCM, this would be a COI (if individuals choose to stay with CDDO in-house TCM or CDDOs encourage in-house TCM)
- Potential for loss of TCMs
- Concern of CDDOs that have separated CSP portion but is still "organization related to another tax-exempt or taxable entity" on 990 forms

## OPTION 2: FREE RESPONSE

### Things to Consider

- TCM rate would need to increase to be competitive with MCO care coordinators
- Wage, personal liability insurance, health insurance, vision and dental coverage, life insurance coverage, retirement, office space, office supplies, vehicle, etc. are costs to consider for independent TCMs
- Monthly billable encounter rate
- Ensuring TCMs are available in local areas so they are knowledgeable of available services in area

### Concerns

- "The reimbursement rate does not cover the benefits and salaries necessary to maintain a stable, professional workforce. Money and time is then spent fundraising. There are no funds for training and proper supervision to assure a quality services."
- Concern that if 40 cases is the caseload TCMs would need to hold to earn a livable wage, not every TCM can hold that depending on where they are (e.g., rural)
- No safety net is a concern

## OPTION 3: FREE RESPONSE

### Benefits

- "This option may preserve capacity better but tracking / monitoring of it will be a lot of work and really limits choice."

### Things to Consider

- "This is probably the best plan in some ways for individuals and families, however a real bummer when the individual/family loves their TCM but really wants to attend the day or res service that is at the same agency. In some ways it restricts choice and would be difficult to track and make sure it is being followed."
- Multiple suggested grandfathering people in
- "TCM entities that are for profit cannot serve individuals who cannot pay for services. They cannot serve individuals who live in extremely rural areas because windshield time

isn't paid for. They cannot serve children without Medicaid without charging them for private pay. Non-profit agencies are key to making sure everyone is served and served locally."

### Concerns

- Could require too much oversight to actually be conflict free
- "This will force providers out of the TCM business, especially in rural areas of the state. The nearly 400 individuals who receive case management from the large agency in Northwest Kansas will need to switch case managers."

Additionally, respondents were asked which transition option they would like to see implemented, either phased or all at once. 100% of respondents (18 responses) chose phased. Of the phased approach options (regional, provider type, service plan end dates, types of services), 54% of respondents (8 out of 15 responses) chose regional as the best phased approach.

**FIGURE 16: TRANSITION OPTION**

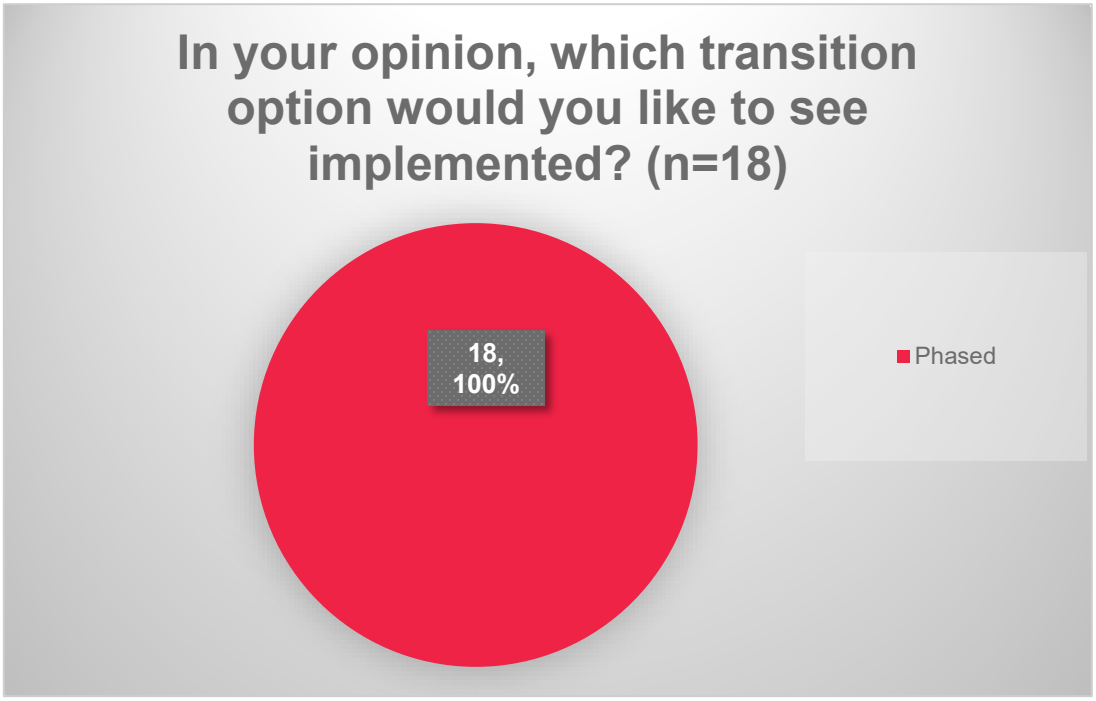
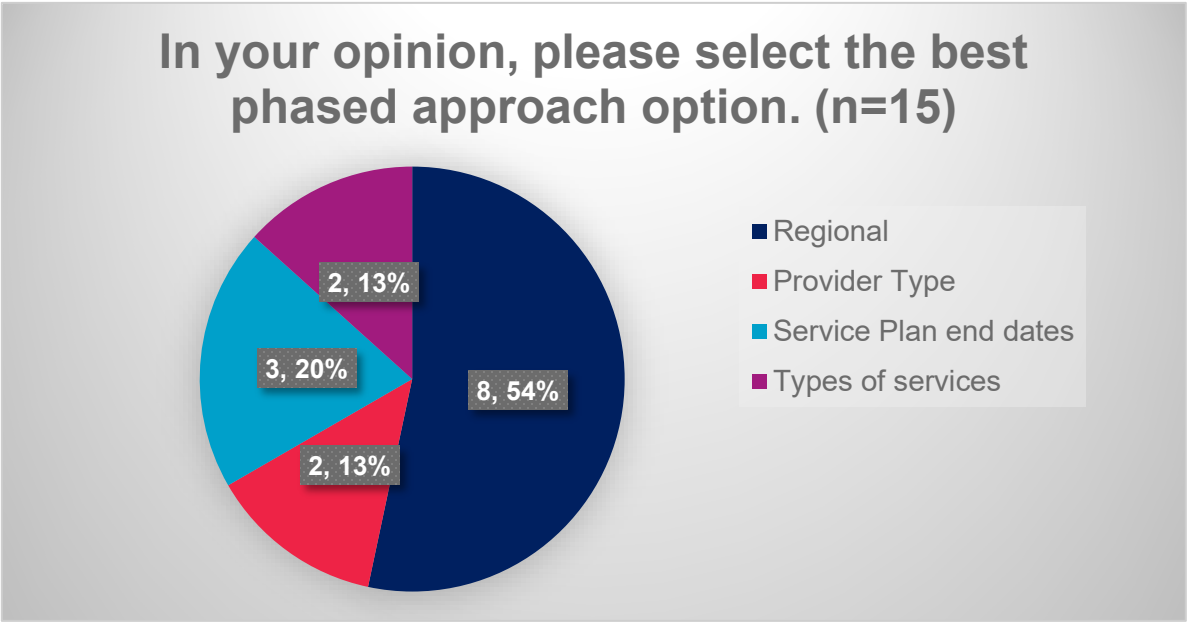


FIGURE 17: BEST PHASED APPROACH OPTION




Respondents were also able to share their opinions and perspectives on the transition approach options in a free response. Key themes from these free responses are detailed below.

## TRANSITION OPTIONS: FREE RESPONSE

### Benefits

- Phased allows for more time to complete paperwork

### Things to Consider

- Timelines must be adhered to with phased approach
- "The other three ideas, Provider Type, Service Plan End Dates and Types of Service are all basically the same as all at once, because the entire state would have to make changes at the same time."
- Rural exception should be considered to give rural areas more time to build capacity to serve individuals

### Concerns

- Concern about transitions in locations with no other TCM providers

Additional considerations from the stakeholder meetings where PCG presented the compliance options to stakeholders and open free response within the compliance options survey are recorded below as well.

## CONSIDERATIONS FROM APRIL BIMONTHLY MEETINGS

- Support needed from the state to encourage independent targeted case managers
    - Targeted case manager liaison
- Option 1: would CDDOs be able to provide TCM as an option or only as a safety net?
- Option 2: how would TCM be assured if there's not safety net option?
- How to address CDDOs performing functions (TCM or direct services) unrelated to CDDO functions – is this still conflicted?
- Phased approach seemed to be preferred transition approach across the board

## FOR COMMUNICATION/MESSAGING PURPOSES

- Clarifying CDDOs will not be able to choose between having TCM and direct services – the state will choose the option and CDDOs will have to develop plans to come into compliance
- Clearly identifying the difference between direct services and targeted case management (stakeholders view TCM as a "direct service" when it isn't)
- MCO functions will not change

## OTHER FREE RESPONSE CONSIDERATIONS

- Stakeholders need to know the decision as soon as possible to prepare
- Contacting individuals/families/guardians – "Community groups like Families Together, Churches that have Family night out, Day and Residential providers, they all have email lists that could be utilized."
    - Making presentations more parent-friendly
- Clarify why increasing oversight won't solve conflict, two respondents suggested a 4$^{th}$ option that increases oversight to ensure quality at agencies that provide both TCM and direct services