

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State of Kansas** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:

Kansas - HCBS-I/DD Waiver

C. Waiver Number:KS.0224

Original Base Waiver Number: KS.0224.

D. Amendment Number:

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

03/01/25

Approved Effective Date of Waiver being Amended: 07/01/24

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

Updated the Level of Care Assessments from BASIS to MFEI-I/DD.

The current BASIS assessment tool used for the HCBS I/DD waiver program in Kansas has been identified as having several limitations. These limitations include a deficit-based approach, an inability to capture the evolving needs of the I/DD population, and misalignment of tiers with actual support needs.

To address these shortcomings and improve the quality of services provided to individuals with intellectual and developmental disabilities, the Kansas Department for Aging and Disability Services (KDADS) proposes transitioning to an InterRAI-based assessment tool. The InterRAI-Home Care (UHC) tool with I/DD additions and the interRAI-Intellectual Disability (iID) tool have been selected as the most suitable replacements.

By implementing this change, KDADS aims to:

- Enhance the accuracy and reliability of functional eligibility assessments.
- Improve the alignment of services with individual needs.
- Strengthen compliance with federal regulations and guidelines (settings final rule).

Transitional Measures and Participant Support

To ensure a smooth transition and minimize disruptions to services, KDADS will implement the following measures:

- The MFEI I/DD is the primary tool for determining functional eligibility for new assessments and current participant’s reassessment.
- During the American Rescue Plan (ARP) Maintenance of Equity (MOE) period, KDADS will utilize a dual assessment approach. This means that both the BASIS and InterRAI-based assessments will still be in use.
 - o To ensure there is no disruption in waiver eligibility, scope, or duration of service during the transition period (ARP MOE Period) KDADS will reassess any current/active waiver participant found ineligible on the new InterRAI-based assessment (MFEI I/DD) using the previous (legacy) BASIS tool.
 - o If the legacy tool (the BASIS) finds the participant eligible, KDADS will sustain the functional eligibility of the participant.
 - o If participant is found ineligible with the MFEI I/DD and the BASIS, current waiver language regarding appeal rights will apply.
 - o This approach will extend throughout the ARP MOE Period.
 - o Participants notifications will follow current procedures as documented in the waiver.
 - o Current waiver language regarding appeal rights, will continue to apply.

Effective Date

KDADS will start using the MFEI I/DD starting March 1, 2025.

Key Considerations

- **Transitional Measures:** To ensure there is no disruption in waiver eligibility, scope, or duration of service during the transition period (2025), KDADS will reassess any current/active waiver participant found ineligible on the new InterRAI-based assessment using the previous (legacy) BASIS tool.
- **Training and Technical Assistance:** KDADS will provide comprehensive training and technical assistance to staff involved in the assessment process.
- It is not anticipated that the person-centered service planning process will change as a result of this change in level of care assessment tool.

Updated Appendix F to reflect current process.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently (*check each that applies*):

Component of the Approved Waiver	Subsection(s)
Waiver Application	<div style="border: 1px solid black; width: 100%; height: 20px;"></div>
Appendix A Waiver Administration	<div style="border: 1px solid black; width: 100%; height: 20px; display: flex; align-items: center; justify-content: center;"> A.6 </div>

Component of the Approved Waiver	Subsection(s)
and Operation	
Appendix B Participant Access and Eligibility	B.6, B.6.d
Appendix C Participant Services	
Appendix D Participant Centered Service Planning and Delivery	D.1
Appendix E Participant Direction of Services	
Appendix F Participant Rights	F.1, F.3
Appendix G Participant Safeguards	
Appendix H	
Appendix I Financial Accountability	
Appendix J Cost-Neutrality Demonstration	

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment (*check each that applies*):

- Modify target group(s)**
 - Modify Medicaid eligibility**
 - Add/delete services**
 - Revise service specifications**
 - Revise provider qualifications**
 - Increase/decrease number of participants**
 - Revise cost neutrality demonstration**
 - Add participant-direction of services**
 - Other**
- Specify:

To change the functional eligibility tool.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The State of Kansas requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (optional - this title will be used to locate this waiver in the finder):

Kansas - HCBS-I/DD Waiver

C. Type of Request: amendment

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

3 years 5 years

Original Base Waiver Number: KS.0224

Draft ID: KS.008.07.01

D. Type of Waiver (select only one):

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/24

Approved Effective Date of Waiver being Amended: 07/01/24

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (check each that applies):

Hospital

Select applicable level of care

Hospital as defined in 42 CFR §440.10

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

[Empty text box for specifying subcategories of hospital level of care]

Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160

Nursing Facility

Select applicable level of care

Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I

Waiver(s) authorized under §1915(b) of the Act.

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

I/DD Waiver. 1915 (b) waiver has been approved.

Specify the §1915(b) authorities under which this program operates (check each that applies):

- §1915(b)(1) (mandated enrollment to managed care)**
- §1915(b)(2) (central broker)**
- §1915(b)(3) (employ cost savings to furnish additional services)**
- §1915(b)(4) (selective contracting/limit number of providers)**

A program operated under §1932(a) of the Act.

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

A program authorized under §1915(i) of the Act.

A program authorized under §1915(j) of the Act.

A program authorized under §1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

This waiver provides services for individuals who are eligible for both Medicare and Medicaid.

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The State of Kansas currently operates an approved Intellectual and/or Developmental Disability (IDD) waiver that provides services to eligible children and adults. The purpose of this waiver is to provide the opportunity for innovation in providing Home and Community-Based Services (HCBS) to eligible participants who would otherwise require institutionalization in an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF-IID).

Consistent with the Developmental Disabilities Reform Act of 1995 (DDRA), the goals and objectives of the waiver continue to center around providing participants, who have intellectual and/or developmental disabilities, access to services and supports which allow opportunities for choices that increase the participant's independence, productivity, integration, and inclusion in the community.

Further, this range of supports and services will be appropriated to each participant and will be provided in a manner that affords the same dignity and respect to participants with intellectual and/or developmental disabilities that would be afforded to any person who does not have a disability.

The services available through the waiver can be delivered through multiple service delivery methods. Some services require licensure and are managed by the provider. Others must be self-directed, while others may be provided through either a provider-managed or participant-directed method.

The move to integrate IDD waiver services into KanCare in 2014 did not and does not diminish the waiver's focus on independent living and participant-driven services. Participants will continue to have a choice between self-directed or agency-directed services.

Programmatic oversight and control of the IDD waiver is provided by the Kansas Department for Aging and Disability Services, Division of Community Services and Programs (KDADS). Consistent with the DDRA, KDADS contracts with Community Developmental Disability Organizations (CDDOs) across the state to implement requirements related to eligibility, access to services, and other duties as defined by the Act.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the state provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

Yes. This waiver provides participant direction opportunities. *Appendix E is required.*

No. This waiver does not provide participant direction opportunities. *Appendix E is not required.*

- F. Participant Rights.** Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):

Not Applicable

No

Yes

C. Statewide. Indicate whether the state requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):

No

Yes

If yes, specify the waiver of statewide requirements that is requested (*check each that applies*):

Geographic Limitation. A waiver of statewide requirements is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state. *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

Limited Implementation of Participant-Direction. A waiver of statewide requirements is requested in order to make *participant-direction of services* as specified in Appendix E available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state. *Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:*

5. Assurances

In accordance with 42 CFR §441.302, the state provides the following assurances to CMS:

A. Health & Welfare: The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in Appendix C, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are inpatients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the state secures public input into the development of the waiver:

This notice was Published in the Kansas Register and sent to the Local Health Departments on November 14, 2024.

State of Kansas
Department for Aging and Disability Services
Public Notice

Request for Comments

The Kansas Department for Aging and Disability Services, KDADS, is amending the following Kansas Medicaid 1915(c) Waiver: HCBS Intellectual Developmental Disabilities (IDD) Waiver.

The proposed amendment covers the following:

To update the Level of Care (LOC) eligibility determination tool from the BASIS assessment to the Medicaid Functional Eligibility Instrument (MFEI).

The proposed effective date for the Intellectual Developmental Disabilities Waiver amendment is March 1, 2025.

The Kansas Department for Aging and Disability Services seeks public comments from the general public on the proposed waivers from November 14, 2024, until midnight on December 14, 2024.

The proposed waiver is posted on the KDADS' website at <https://www.kdads.ks.gov> under Services & Programs, then Long-Term Services & Supports page and then Home and Community Based Services (HCBS), and then Waiver Renewal/Amendment:

By e-mail:

Kansas Department for Aging and Disability Services
kdads.hcbs-ks@ks.gov

By standard mail:

Kansas Department for Aging and Disability Services
Attn: IDD Waiver Manager
503 S. Kansas Avenue
Topeka, KS 66603

Draft copies of the proposed amendment may also be found at Local Health Departments.

Comments may be made in any one of the following ways:

Online (KDADS website):

<https://www.kdads.ks.gov> under Services & Programs, then Long-Term Services & Supports page and then Home and Community Based Services (HCBS), and then HCBS Notices & Memos

By e-mail:

Kansas Department for Aging and Disability Services
kdads.hcbs-ks@ks.gov

By standard mail:

Kansas Department for Aging and Disability Services
Attn: HCBS Programs
503 S. Kansas Avenue
Topeka, KS 66603

Laura Howard
Secretary

Tribal Notice was sent on November 14, 2024.

This section will be updated at the conclusion of the comment period with comments and any actions taken as a result of those comments.

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a

Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

Weiter

First Name:

Kurt

Title:

Director of Compliance and Contracting

Agency:

Kansas Department of Health and Environment

Address:

Landon State Office Bldg-Room 900 N

Address 2:

900 SW Jackson

City:

Topeka

State:

Kansas

Zip:

66612-1220

Phone:

(785) 296-8623

Ext:

TTY

Fax:

(785) 296-4813

E-mail:

kurt.weiter@ks.gov

B. If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

Farwell

First Name:

Letha

Title:

Agency:

Address:

Address 2:

City:

State: **Kansas**

Zip:

Phone: **Ext:** **TTY**

Fax:

E-mail:

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State:

Kansas

Zip:

Phone:

Ext:

TTY

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

Replacing an approved waiver with this waiver.

Combining waivers.

Splitting one waiver into two waivers.

Eliminating a service.

Adding or decreasing an individual cost limit pertaining to eligibility.

Adding or decreasing limits to a service or a set of services, as specified in Appendix C.

Reducing the unduplicated count of participants (Factor C).

Adding new, or decreasing, a limitation on the number of participants served at any point in time.

Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.

Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

Updated the Level of Care Assessment from BASIS to MFEI-I/DD.

Transitional Measures: To ensure there is no disruption in waiver eligibility, scope, or duration of service during the transition period (ARP MOE), KDADS will reassess any current/active waiver participant found ineligible on the new InterRAI-based assessment using the previous (legacy) BASIS tool.

- Training and Technical Assistance: KDADS will provide comprehensive training and technical assistance to staff involved in the assessment process.
- It is not anticipated that the person-centered service planning process will change as a result of this change in level of care assessment tool.
- Participants can request a Fair Hearing by following the process in Appendix F.
- The State will engage with stakeholders, including Participants, on the waiver amendment for their feedback before and during the Public Comment period.
- Participants will be notified of the assessment change again when their assessment is completed.
- CDDOs will be actively trained for the MFEI-I/DD and will notify Participants of that tool prior to the assessment.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings

requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

•One unit of a service delivered virtually, shall be equivalent to one unit of in person service delivery (the same) when provided through virtual delivery of a service and shall be reimbursed equivalently.

•MCOs shall require providers delivering virtual services to have backup plans in the event of failure of the virtual delivery of service solution.

The state may require MCOs to present a sample of their provider backup plans for virtual delivery of a service.

•If a technology or device is provided to the participant for the primary purpose of virtual delivery of a service, placement of such devices/equipment/technology shall be solely determined by the participant.

•The participant shall have total control of the device, including turning it off or on.

•It shall be documented in the service plan what happens if and when a participant decides to turn off the equipment.

-Virtual delivery of service would not be authorized for a person who required hands on or physical assistance. The approved task, frequency and duration of virtual delivery of service will be documented in the Person Centered Service Plan.

-Virtual supports may only be permitted in bedrooms and bathrooms when an evaluation of multiple factors show that the technology increases independence and facilitates each participant's right to privacy of person and possession.

Virtual Services in bedrooms and bathrooms can only be provided with signed consent of the participant/guardian, the person's support team and the MCO.

Virtual delivery of service in bedrooms and bathrooms must be approved in the Person Centered Service Plan with a plan to fade the service as appropriate.

Telehealth services will promote community integration: Virtual delivery of services allows the participant more autonomy and independence in choice making. It incentivizes community integration in step with the ADA Integration Mandate and Olmstead Decision which prioritizes services in the most integrated settings for individuals with disabilities.

Telehealth will ensure the health and safety of an individual: The provider and MCO are required to ensure health and safety can be maintained with this mode of service delivery.

Regarding services for individuals who need hands-on or physical assistance: Services that require hands on or physical assistance will not be approved for virtual delivery of service.

The state will support individuals who need assistance with using the technology required for telehealth delivery of the services: The level of support required via training or education will be defined in the Person Centered Service Plan. Each participant who utilizes virtual delivery of a service needs to be assessed for their level of independence for this mode of service delivery.

Regarding the percentage of time telehealth will be the delivery method for each service: Each participant will make this determination via their Person Centered Service Plan.

Regarding the requirement for in-person visits: Each participant will make this determination via their Person Centered Service Plan. Participants will have a choice of in person or virtual delivery of services.

Regarding telehealth delivery of each service meeting HIPAA requirements: Telehealth delivery of service will meet HIPAA requirements.

Virtual delivery of services will meet the privacy of the individual, especially in instances of toileting, dressing, etc., as video cameras/monitors are not permitted in bedrooms and bathrooms: The participant will design their own privacy parameters for virtual delivery use per services; this will be outlined in the Person Centered Service Plan.

Appendix A: Waiver Administration and Operation

1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver (*select one*):

The waiver is operated by the state Medicaid agency.

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one*):

The Medical Assistance Unit.

Specify the unit name:

(Do not complete item A-2)

Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.

Specify the division/unit name:

Kansas Department for Aging and Disability Services (KDADS)

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

Kansas Department of Health and Environment (KDHE), which is the single state Medicaid agency (SSMA), and the Kansas Department for Aging and Disability Services (KDADS) have an interagency agreement which, among other things:

- Specifies that the SSMA is the final authority on compensatory Medicaid costs.
- Recognizes the responsibilities imposed upon the SSMA as the agency authorized to administer the Medicaid program, and the importance of ensuring that the SSMA retains final authority necessary to discharge those responsibilities.
- Requires the SSMA approve all new contracts, MOUs, grants or other similar documents that involve the use of Medicaid funds.
- Notes that the agencies will work in collaboration for the effective and efficient operation of Medicaid health care programs, including the development and implementation of all program policies, and for the purpose of compliance with all required reporting and auditing of Medicaid programs.
- Requires the SSMA to provide KDADS with professional assistance and information, and both agencies to have designated liaisons to coordinate and collaborate through the policy implementation process.
- Delegates to KDADS the authority for administering and managing certain Medicaid-funded programs, including those covered by this waiver application.
- Specifies that the SSMA has final approval of regulations, State Plan Amendments (SPAs) and Medicaid Management Information System (MMIS) policies, is responsible for the policy process, and is responsible for the submission of applications/amendments to CMS in order to secure and maintain existing and proposed waivers, with KDADS furnishing information, recommendations and participation. (The submission of this waiver application is an operational example of this relationship. Core concepts were developed through collaboration among program and operations staff from both the SSMA and KDADS; functional pieces of the waiver were developed collectively by KDHE and KDADS staff; and overview/approval of the submission was provided by the SSMA, after review by key administrative and operations staff and approval of both agencies' leadership.) The state leadership-level meetings occur weekly and additional meetings occur as needed.

In addition to leadership-level meetings to address guiding policy and system management issues (both ongoing periodic meetings and as needed, issue-specific discussions), the SSMA ensures that KDADS performs assigned operational and administrative functions by the following means:

- a. Regular meetings are held by the SSMA with representatives from KDADS to discuss:
 - Information received from CMS;
 - Proposed policy changes;
 - Waiver amendments and changes;
 - Data collected through the quality review process
 - Eligibility, numbers of providers being served
 - Fiscal projections; and
 - Any other topics related to the waivers and Medicaid.
- b. All policy changes related to the waivers are approved by KDHE. This process includes a face to face meeting with KDHE staff.
- c. Waiver renewals, 372 reports, any other federal reporting requirements, and requests for waiver amendments must be approved by KDHE.
- d. Correspondence with CMS is copied to KDHE.

Kansas Department of Health and Environment, as the single state Medicaid agency, has oversight responsibilities for all Medicaid programs, including direct involvement or review of all functions related to HCBS waivers. KDHE has oversight of all portions of the program and the KanCare MCO contracts, and does collaborate with KDADS regarding HCBS program management, including those items identified in part (a) above. The key component of that collaboration has been through the long term care meetings, KanCare Steering meetings, joint policy meetings, are all important parts of the overall state's KanCare Quality Improvement Strategy, which provides quality review and monitoring of all aspects of the KanCare program – engaging program management, contract management, and financial management staff from both KDHE and KDADS. The services in this waiver are part of the state's KanCare comprehensive Medicaid managed care program. The quality monitoring and oversight for the program, and the interagency monitoring (including the SSMA's monitoring of delegated functions to the Operating Agency) is guided by the joint long term care (LTC) meetings. A critical component of that strategy is the engagement of the LTC stakeholders, which brings together leadership, program management, contract management, fiscal management and other staff/resources to collectively monitor the extensive reporting, review results and other quality information and data related to the

KanCare program and services. Because of the managed care structure, and the integrated focus of service delivery/care management, the core monitoring processes – including LTC meetings – is on a quarterly basis. Continuous monitoring is being conducted, including on monthly and other intervals, the aggregation, analysis and trending processes will be built around that quarterly structure.

All oversight activities delegated by KDHE to KDADS are expressly identified in the standard operating procedures as well as in the body of the Memorandum of Understanding (MOU) between KDHE and KDADS. The MOU will be reviewed and updated at a minimum 5 years from the effective date (section XIV.a). This does not preclude the parties from reviewing and updating the MOU at any time after the effective date by mutual agreement of the parties. Also the SOP's can be updated at any time without having to amend the MOU.

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

Community Developmental Disability Organizations (CDDOs):

CDDOs could be considered both contracted entities as well as local/regional non-state entities.

Consistent with the Developmental Disabilities Reform Act of 1995 (DDRA), KDADS contracts with CDDOs across the State to perform the following functions;

*Directly or by subcontract, serve as a single point of application of referral for services, to assist all participants with a developmental disability to have access to and an opportunity to participate in community services and;

*Provide either directly or by subcontract, services to persons with IDD, including eligibility determination and explanation of available services and service providers, and referring individuals for determination of Medicaid and/or disability eligibility determination.

*Waiver enrollment managed against approved limits: KDADS is responsible for applying the State's policies concerning the selection of individuals to enter the waiver and for maintenance of a waiting list for entrance to the waiver. The CDDOs are responsible for ensuring that the people who wish to be added to the waitlist have an accurate assessment that complies with the timeframes in KDADS' Functional Assessment and Waitlist Management policy.

The CDDOs are also responsible for data entry into the KDADS' system of record, and that KDADS is informed when a person should be removed from the waitlist due to death, a move out of state, institutionalization, voluntary removal, program and functional ineligibility, and other reasons.

*Level of care evaluation: CDDO activities include compiling and submitting to the State the information that is necessary to evaluate potential entrance to the waiver and the continuing need for the level of care that the waiver provides for participants.

Related to that data collection, the CDDOs, as the state's contracted assessing entity, conduct participant waiver assessments to determine the participant's functional eligibility and level of care, as well as options counseling, in order to capture and ensure participant choice.

Managed Care Organizations conduct Service Plan development and related service authorization, assist with utilization management, conduct provider credentialing, create and provide the provider manual, and other provider guidance; and participate in the comprehensive state quality improvement strategy for the KanCare program, including this waiver.

The MCOs' engage the participant to develop a Person-Centered Service Plan. The MCO's are responsible for ensuring paid support staff or other professionals carry out the Service Plan that supports the participant's inclusion in the community. Once the MCOs complete the Person-Centered Service Plan, a review is completed to ascertain the specific services, frequency and duration required to meet the needs of the participant as identified in the service plan.

Some approved waiver services do require prior authorizations before the services are administered. The MCOs' provide utilization management and oversight of the service plans for waiver participants.

KDHE contracts with a Medicaid fiscal agent to enroll providers in the Medicaid program in compliance with federal law. The Medicaid fiscal agent and KDHE review the provider application prior to approving the provider's enrollment in the Medicaid program. The MCOs contract and credential providers within their network.

KDHE contracts with an EQRO to perform the EQRO defined functions for managed care.

The KDHE DHCF contracted actuary analyzes the MCOs' paid claims to determine the capitation rate (PMPM) for the waiver.

KDHE DHCF's contract with the MCOs requires the MCOs to provide medically necessary services to eligible Medicaid members. The MCOs' are contractually required to provide reporting to the State and address quality concerns.

No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

Appendix A: Waiver Administration and Operation

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

Not applicable

Applicable - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

Local/Regional non-state public agencies perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

Community Developmental Disability Organizations (CDDOs):
 CDDOs could be considered both contracted entities as well as local/regional non-state entities. Consistent with the Developmental Disabilities Reform Act of 1995 (DDRA), KDADS contracts with CDDOs across the State to perform the following functions;

- *Directly or by subcontract, serve as a single point of application of referral for services, to assist all participants with a developmental disability to have access to and an opportunity to participate in community services and;
- *Provide either directly or by subcontract, services to persons with IDD, including eligibility determination and explanation of available services and service providers, and referring individuals for determination of Medicaid and/or disability eligibility determination.
- *Waiver enrollment managed against approved limits: KDADS is responsible for applying the State’s policies concerning the selection of individuals to enter the waiver and for maintenance of a waiting list for entrance to the waiver. The CDDOs are responsible for ensuring that the people who wish to be added to the waitlist have an accurate assessment that complies with the timeframes in KDADS' Functional Assessment and Waitlist Management policy.

The CDDOs are also responsible for data entry into the KDADS’ system of record, and that KDADS is informed when a person should be removed from the waitlist due to death, a move out of state, institutionalization, voluntary removal, program and functional ineligibility, and other reasons.

- *Level of care evaluation: CDDO activities include compiling and submitting to the State the information that is necessary to evaluate potential entrance to the waiver and the continuing need for the level of care that the waiver provides for participants.

Related to that data collection, the CDDOs, as the state's contracted assessing entity, conduct participant waiver assessments to determine the participant's functional eligibility and level of care, as well as options counseling, in order to capture and ensure participant choice.

Managed Care Organizations conduct Service Plan development and related service authorization, assist with utilization management, conduct provider credentialing, create and provide the provider manual, and other provider guidance; and participate in the comprehensive state quality improvement strategy for the KanCare program, including this waiver.

Local/Regional non-governmental non-state entities conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities. Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

KDHE holds the contract for the Managed Care Organizations. KDHE holds regular quality assurance and oversight activities for the MCOs'. KDHE contracts with an EQRO to review MCO's contracts and compliance with those contracts. KDHE is responsible for the financial eligibility before the participants are granted access to the waiver. KDHE issues eligibility determination letters and appeal rights if not found eligible.

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

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

Appendix A: Waiver Administration and Operation

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

Contracted entities and the state’s KanCare managed care organizations are monitored through the State’s KanCare Quality Improvement Strategy, which provides quality review and monitoring of all aspects of the KanCare program – engaging program management, contract management, and financial management staff from both KDHE and KDADS.

All functions delegated to contracted entities are included in the State's comprehensive quality strategy review processes. In addition, the SSMA and State operating agency KDADS will continue to operate collaboratively under an interagency agreement, as addressed in part A.2.b above, and that agreement includes oversight and monitoring of all HCBS programs, the KanCare MCOs and independent assessment contractors.

The KanCare Quality Improvement Strategy ensure that the entities contracting with KDADS (the Waiver Operating Agency) are operating within the established parameters. These parameters include CMS rules/guidelines, the approved KanCare managed care contracts and related CMS 1915B waiver regulations and guidelines and Kansas statutes and regulations, and related policies. Included in the QIS is an ongoing assessment of the results of onsite monitoring and reviews with a sample of HCBS waiver participants.

KDADS oversees the contract with the qualified assessor to ensure that assessors meet current educational and training requirements to conduct the MFEI-I/DD assessment with children and adults in Kansas. The Level of care assessment, the MFEI-I/DD assessment, is completed by the assessing entity, reviewed and approved by the KDADS Program Manager.

Once assessment is completed by the assessing entity and result send to KDADS, KDADS determines the functional eligibility, and those found functionally eligible are sent to KDHE for financial eligibility determination

KDHE as the SSMA manages the contracts with the Managed Care Organizations in Kansas. KDADS oversees a quarterly review process with each MCO in Kansas. KDADS oversees this quarterly review process to ensure accuracy and appropriateness of the Person-Centered Service Plan, to ensure health and welfare of the waiver participant, to ensure adequacy of qualified providers and to ensure financial accuracy in billing. KDADS Quality Assurance Team reviews quarterly submissions from the contracted assessor to ensure accurate information is being obtained and the MFEI-I/DD assessments are being completed correctly within the appropriate timeframe.

KDADS Quality Assurance Team requires the contracted assessor to provide the following documents for each participant assessed:

1. MFEI-I/DD Assessments or BASIS Assessments
2. Referral form from KDADS for the assessment.
3. Approved form from KDADS Program Manager
4. Recommended Service Plan

KDADS Quality Assurance Team reviews quarterly submissions from Managed Care Organizations to ensure the accuracy and appropriateness of the Person-Centered Service Plan, to ensure the health and welfare of the participants, to ensure the adequacy of qualified providers, and to ensure financial accuracy in billing.

Appendix A: Waiver Administration and Operation

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment				

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Waiver enrollment managed against approved limits				
Waiver expenditures managed against approved levels				
Level of care evaluation				
Review of Participant service plans				
Prior authorization of waiver services				
Utilization management				
Qualified provider enrollment				
Execution of Medicaid provider agreements				
Establishment of a statewide rate methodology				
Rules, policies, procedures and information development governing the waiver program				
Quality assurance and quality improvement activities				

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of waiver policies developed by the Operating Agency that were approved by the State Medicaid Agency prior to implementation N=Number of waiver policies developed by the Operating Agency that were approved by the State Medicaid Agency prior to implementation D=Number of waiver policies developed by the Operating Agency

Data Source (Select one):

Other

If 'Other' is selected, specify:

State Policy Documentation

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input type="text"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Number and percent of Long-Term Care Committee meetings that were represented by the OA program managers and SSMA waiver managers through in-person attendance or written reports
N=Number of Long-Term Care Committee meetings that were represented by the OA program managers and SSMA waiver managers through in-person attendance or written reports
D=Number of Long-Term Care meetings

Data Source (Select one):

Other

If 'Other' is selected, specify:

State Long Term Care Meeting documentation

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify:

		<input type="checkbox"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Number and percent of MCO quality improvement plans developed by the MCO, reviewed (and approved) by the SSMA and OA N=Number of quality improvement plans reviewed (and approved) by the SSMA and OA D=Number of quality improvement plans created by the MCO.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Quality Improvement Plans

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review

Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="Managed Care Organizations"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Kansas Department of Health and Environment, Division of Health Care Finance (KDHE), the single state Medicaid agency, and Kansas Department for Aging and Disability Services (KDADS) work together to develop state operating agency priority identification regarding all waiver assurances and minimum standards/basic assurances. The state agencies work in partnership with participants, advocacy organizations, provider groups and other interested stakeholders to monitor the state quality strategy and performance standards and discuss priorities for remediation and improvement. The state quality management strategy (or QMS) includes protocols to review cross-service system data to identify trends and opportunities for improvement related to all Kansas waivers, policy and procedure development and systems change initiatives. Data gathered by KDADS Regional Staff during the Quality Survey Process is compiled quarterly for evaluation and trending to identify areas for improvement. Upon completion of identified areas of improvement this information is compiled into reports and shared both internally and externally, including with KDHE. As the KanCare program has been operationalized, staff of the three plans have and will be engaged with state staff to ensure a strong understanding of Kansas’ waiver programs and the quality measures associated with each waiver program. These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through a state interagency monitoring component, which includes program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

b. Methods for Remediation/Fixing Individual Problems

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

State staff and/or KanCare MCO staff request, approve, and assure implementation of provider corrective action planning and/or technical assistance to address non-compliance with waiver and performance standards as detected through on-site monitoring, survey results and other performance monitoring. These processes are monitored by both program managers and other relevant state and MCO staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy. Monitoring and survey results are compiled, trended, reviewed, and disseminated consistent with protocols identified in the statewide quality improvement strategy. Each provider receives annual data trending which identifies Provider specific performance levels related to statewide performance standards and statewide averages. Corrective Action Plan requests, technical assistance and/or follow-up to remediate negative trending are included in annual reports where negative trending is evidenced.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="text"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR Â§441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
Aged or Disabled, or Both - General					
		Aged		<input type="checkbox"/>	<input type="checkbox"/>
		Disabled (Physical)		<input type="checkbox"/>	<input type="checkbox"/>
		Disabled (Other)		<input type="checkbox"/>	<input type="checkbox"/>
Aged or Disabled, or Both - Specific Recognized Subgroups					
		Brain Injury		<input type="checkbox"/>	<input type="checkbox"/>
		HIV/AIDS		<input type="checkbox"/>	<input type="checkbox"/>
		Medically Fragile		<input type="checkbox"/>	<input type="checkbox"/>
		Technology Dependent		<input type="checkbox"/>	<input type="checkbox"/>
Intellectual Disability or Developmental Disability, or Both					
		Autism	5	<input type="checkbox"/>	<input type="checkbox"/>

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
		Developmental Disability	5		
		Intellectual Disability	5		
Mental Illness					
		Mental Illness			
		Serious Emotional Disturbance			

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

The criteria for IDD program and functional eligibility are as follows:

1. Must be 5 years of age or older;
2. Have Intellectual Disability that began before the age of 18, and/or, have a diagnosis of a Developmental Disability that began before the age of 22;
3. Must be determined program eligible by the Community Disability Determination Organization;
4. Meet the Medicaid long-term care institutional threshold score using the State's functional eligibility instrument;
5. Be financially eligible for Medicaid
6. Be a resident of the State of Kansas

Qualifying IDD waiver applicants have either an ID that began before age 18 OR a DD that began before age 22.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (*select one*):

Not applicable. There is no maximum age limit

The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*). Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

No Cost Limit. The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

Cost Limit in Excess of Institutional Costs. The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

The limit specified by the state is (*select one*)

A level higher than 100% of the institutional average.

Specify the percentage:

Other

Specify:

Institutional Cost Limit. Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

Cost Limit Lower Than Institutional Costs. The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the state is (select one):

The following dollar amount:

Specify dollar amount:

The dollar amount (select one)

Is adjusted each year that the waiver is in effect by applying the following formula:

Specify the formula:

May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.

The following percentage that is less than 100% of the institutional average:

Specify percent:

Other:

Specify:

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

The participant is referred to another waiver that can accommodate the individual's needs.

Additional services in excess of the individual cost limit may be authorized.

Specify the procedures for authorizing additional services, including the amount that may be authorized:

Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	9895
Year 2	9895
Year 3	9895
Year 4	9895
Year 5	9895

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

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

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

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	9611
Year 2	9611
Year 3	9611
Year 4	9611
Year 5	9611

Appendix B: Participant Access and Eligibility

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

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

Not applicable. The state does not reserve capacity.

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

Purpose(s) the state reserves capacity for:

Purposes
Children determined to be no longer eligible for the Autism (AU) Waiver
Temporary Institutional Stay
Children determined to be no longer eligible for the Technology Assisted (TA) waiver
Children coming into the custody of the Department of Children and Families (DCF)
HCBS Institutional Transitions
Military Inclusion
Participants determined to be no longer eligible for the Brain Injury (BI) waiver
WORK Program Transitions

Appendix B: Participant Access and Eligibility

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

Purpose (*provide a title or short description to use for lookup*):

Children determined to be no longer eligible for the Autism (AU) Waiver

Purpose (*describe*):

Children who have been determined to be no longer eligible for the Autism waiver, and who have been determined to be eligible for the IDD waiver will have immediate access to the IDD waiver and will not have to be on the waiting list.

Children cannot transition from the Autism waiver to the IDD waiver unless they are determined to be no longer eligible for the Autism waiver.

Describe how the amount of reserved capacity was determined:

The amount of reserved capacity was determined by historical data regarding the average number of children who are determined to be no longer eligible for the Autism waiver but have been determined to be eligible for the IDD waiver.

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

Waiver Year	Capacity Reserved
Year 1	10
Year 2	10
Year 3	10
Year 4	10
Year 5	10

Appendix B: Participant Access and Eligibility

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

Purpose (provide a title or short description to use for lookup):

Temporary Institutional Stay

Purpose (describe):

The State reserves capacity to maintain continued waiver eligibility for participants who enter into an institution such as hospitals, ICF-IIDs or nursing facilities for the purpose of seeking treatment for acute, habilitative or rehabilitative conditions on a temporary basis of less than 60 days. A temporary stay is defined as a stay that includes the month of admission and two months following admission. Individuals that remain in the institution following the two-month allotment will be terminated from the IDD waiver. After 60 days, the individual may utilize the Institutional Transition process, as described in the HCBS Institutional Transition policy.

Describe how the amount of reserved capacity was determined:

The amount of reserved capacity was determined by historical data regarding the average number of participants who have been admitted for Temporary Institutional Stays.

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

Waiver Year	Capacity Reserved
Year 1	50
Year 2	50

Waiver Year	Capacity Reserved
Year 3	50
Year 4	50
Year 5	50

Appendix B: Participant Access and Eligibility

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

Purpose (provide a title or short description to use for lookup):

Children determined to be no longer eligible for the Technology Assisted (TA) waiver

Purpose (describe):

Children who have been determined no longer eligible for the Technology Assisted waiver, and who have been determined to be eligible for the IDD waiver will have immediate access to the IDD waiver and will not be required to go on a waiting list.

Participants cannot transition from the TA waiver to the IDD waiver unless they are determined to be no longer eligible for the TA waiver.

Describe how the amount of reserved capacity was determined:

The amount of reserved capacity was determined by the historical data of the average number of persons determined to be no longer eligible for the TA waiver but have been determined eligible for the IDD waiver.

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

Waiver Year	Capacity Reserved
Year 1	15
Year 2	15
Year 3	15
Year 4	15
Year 5	15

Appendix B: Participant Access and Eligibility

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

Purpose (provide a title or short description to use for lookup):

Children coming into the custody of the Department of Children and Families (DCF)

Purpose (describe):

KDADS will serve children who have been determined eligible for the IDD waiver who come into custody of DCF. Access to services will be available to those children immediately in accordance with the Crisis and Exception policy. Waiver services will only be provided to those children in DCF custody living in licensed foster care living arrangements or in their home of reintegration.

These waiver services will not duplicate services available under other resources. Foster parents of waiver participants cannot be the paid provider of waiver-funded supports to their foster child. Access to services will not be available for the purpose of maintenance (including room and board) and care defined by DCF as mandated via the foster parent reimbursement.

Describe how the amount of reserved capacity was determined:

The amount of reserved capacity is based on historical data of the average number of these individuals we would expect to apply for IDD services during a year.

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

Waiver Year	Capacity Reserved
Year 1	70
Year 2	70
Year 3	70
Year 4	70
Year 5	70

Appendix B: Participant Access and Eligibility

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

Purpose (provide a title or short description to use for lookup):

HCBS Institutional Transitions

Purpose (describe):

The State reserves capacity for people transitioning from applicable institutional settings into the community. These approved transitions formerly occurred under the Money Follows the Person (or MFP) grant.

In addition, individuals transitioning from a Psychiatric Residential Treatment Facility (PRTF) are eligible for an institutional transition in accordance with the HCBS Institutional Transition policy. IDD waiver eligible individuals who meet criteria for transitioning from the institutional setting into the community will have immediate access to IDD services by completing the process as indicated in the HCBS Transition policy.

Describe how the amount of reserved capacity was determined:

The amount of reserved capacity was determined based on the historical average of the number of persons who had chosen to enter the former MFP program (30 yearly), as well as the historical average of the number of persons transferring from a PRTF annually (15).

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

Waiver Year	Capacity Reserved
Year 1	45
Year 2	45
Year 3	45
Year 4	45
Year 5	45

Appendix B: Participant Access and Eligibility

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

Purpose (provide a title or short description to use for lookup):

Military Inclusion

Purpose (describe):

The State reserves capacity for military participants and their immediate dependent family members to access the IDD waiver in accordance with the Military Inclusion policy.

Describe how the amount of reserved capacity was determined:

Reserved capacity was determined based on the past 5 years of participants utilizing this exception, on average, less than 2 participants per year.

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

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

Appendix B: Participant Access and Eligibility

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

Purpose (provide a title or short description to use for lookup):

Participants determined to be no longer eligible for the Brain Injury (BI) waiver

Purpose (describe):

Participants who have been determined no longer eligible for the BI waiver, and who have been determined to be eligible for the IDD waiver, will have immediate access to the IDD waiver, and will not be placed on the waiting list, in accordance with the HCBS BI Transition policy.

Participants must be determined no longer eligible for the BI waiver in order to transition onto the IDD waiver.

Describe how the amount of reserved capacity was determined:

The amount of reserved capacity was determined by historical data regarding the average number of participants who have been determined to no longer be eligible for the BI waiver and have been determined to be eligible for the IDD waiver.

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

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

Appendix B: Participant Access and Eligibility

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

Purpose (provide a title or short description to use for lookup):

WORK Program Transitions

Purpose (describe):

The State reserves capacity for IDD program participants who have participated in the WORK program, in accordance with the HCBS Working Healthy/WORK Transition policy. Participants have the option to return to the program and bypass the waitlist, if the person was already on the waiver prior to beginning the WORK program.

Describe how the amount of reserved capacity was determined:

The amount of reserved capacity is determined using actual number of past participants who transition back to the IDD waiver from the WORK program.

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

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

Appendix B: Participant Access and Eligibility

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

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):

The waiver is not subject to a phase-in or a phase-out schedule.

The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity.

Select one:

Waiver capacity is allocated/managed on a statewide basis.

Waiver capacity is allocated to local/regional non-state entities.

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

- 1.The IDD Program Eligibility policy establishes the criteria for IDD program eligibility.
- 2.The Functional Eligibility Assessments and Waitlist Management policy establishes functional eligibility criteria and the process by which eligible individuals are made active on the IDD waitlist.
- 3.The Crisis and Exception policy establishes the process allowing eligible individuals to apply to by-pass the waitlist.
- 4.The HCBS Institutional Transition policy establishes the process for allowing eligible individuals, discharging from an approved institutional setting, to access the IDD waiver.
- 5.The Military Inclusion policy identifies the process for eligible military participants and their immediate dependent family members to access the IDD waiver.
- 6.The KDADS Working Healthy/WORK policy identifies the process for individuals to access the IDD waiver from the WORK program.
- 7.The BI Transition policy identifies the process for eligible individuals to transition from the BI waiver to the IDD waiver.

All future access to the HCBS waiver will be determined on a first-come-first-serve basis based on each person's requested date for service.

For those persons who are determined to be in crisis or imminent risk of crisis, and whose needs can only be met through services available through the IDD waiver, these persons will have immediate access to services, subject to their assessed needs for services, based on the criteria established in the Crisis and Exception policy.

Per Kansas Crisis and Exception Policy, all persons requesting access to HCBS-IDD waiver program services must meet IDD eligibility standards and functional eligibility requirements. Functional Eligibility Assessments and Waitlist Management Policy explains the process, procedures, and requirements for assessors, assessment entry timeframes, quality assurance and reporting, and IDD waitlist management.

All requests for crisis or exception access to the HCBS-IDD waitlist will be made through the CDDO in the area in which the person resides. Prior to submission of a crisis or exception request, the person must have a current functional eligibility assessment performed within the past 365 days that indicates functional eligibility.

Crisis Access:

Persons are determined to be in crisis under the following conditions:

1. Documentation from law enforcement or DCF support the need for the person's protection from confirmed abuse, neglect, or exploitation.
2. Documentation substantiating that the person is at significant, imminent risk, and is capable of performing serious harm to self or others.

The CDDOs are responsible for providing all supporting documentation necessary for the State to render a determination for a crisis request. Administration Reconsideration and Appeal Rights are provided in the event of a KDADS denial outcome.

Exception Access:

Exception access may be provided to a person in the following situations:

1. Persons in the custody of the Department of Children and Families (DCF) for the purpose of addressing non-supervision support needs related specifically to the person's IDD diagnosis. Services in this case shall not duplicate services already being provided.
2. Persons who have been determined to be at imminent risk of coming into DCF custody. Exception access in this case would be to assure that the person avoids DCF custody. DCF or court documentation would be required to justify this exception.
3. Persons under the age of 18 who are transitioning from DCF custody. DCF or court documentation is required to justify this exception.
4. Persons 18 years old and older who are transitioning from DCF custody. DCF or court documentation is required to justify this exception.
5. Persons who have successfully transitioned from Vocational Rehabilitation Services (VRS) who require on-going support to maintain employment and self-sufficiency. Documentation of a successful VRS case closure indicating a need for continued supports is required in order to justify this exception.
6. Persons meeting the criteria set forth in the KDADS' Military Inclusion Policy. Documentation requirements include a DD 214 Form and proof of residency.
7. Persons previously on the IDD waiver transferring back to the IDD waiver from the WORK program.
8. Persons meeting the criteria established in the HCBS Institutional Transition Policy, and who also meet IDD program and functional eligibility criteria, if coming out of an approved institutional setting minimum stay of sixty (60) consecutive days prior to applying for an institutional transition, can by-pass the IDD waiver waitlist, and be immediately placed on IDD waiver services.

Transitions from other waivers:

The following HCBS programs shall transition to the IDD waiver program if they meet IDD waiver program and functional eligibility:

1. Persons determined no longer eligible for the Brain Injury waiver.
2. Persons determined no longer eligible for the Technology Assisted waiver.
3. Children determined no longer eligible for the Autism waiver.
4. Upon approval from KDADS, an exception can be made when it is determined that the IDD waiver is the most appropriate considering the person's health and safety.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

- a. **1. State Classification.** The state is a (*select one*):

§1634 State

SSI Criteria State

209(b) State

- 2. Miller Trust State.**

Indicate whether the state is a Miller Trust State (*select one*):

No

Yes

- b. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

Low income families with children as provided in §1931 of the Act

SSI recipients

Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121

Optional state supplement recipients

Optional categorically needy aged and/or disabled individuals who have income at:

Select one:

100% of the Federal poverty level (FPL)

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

Specify percentage:

Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)

Working individuals with disabilities who buy into Medicaid (TWWIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)

Working individuals with disabilities who buy into Medicaid (TWWIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)

Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility

group as provided in §1902(e)(3) of the Act)

Medically needy in 209(b) States (42 CFR §435.330)

Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)

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

Specify:

Parents and other caretaker relatives (42 CFR 435.110); pregnant women (42 CFR 435.116); and children(42 CFR 435.118).

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

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

Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.

Select one and complete Appendix B-5.

All individuals in the special home and community-based waiver group under 42 CFR §435.217

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

Check each that applies:

A special income level equal to:

Select one:

300% of the SSI Federal Benefit Rate (FBR)

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

Specify percentage:

A dollar amount which is lower than 300%.

Specify dollar amount:

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

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

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

Aged and disabled individuals who have income at:

Select one:

100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses spousal post-eligibility rules under §1924 of the Act.

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

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

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

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

Use spousal post-eligibility rules under §1924 of the Act.

(Complete Item B-5-b (SSI State) and Item B-5-d)

Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)

(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.

(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

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

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

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

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

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

The following standard included under the state plan

Select one:

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

(select one):

300% of the SSI Federal Benefit Rate (FBR)

A percentage of the FBR, which is less than 300%

Specify the percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the state Plan

Specify:

The following dollar amount

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

The following formula is used to determine the needs allowance:

Specify:

Other

Specify:

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

Not Applicable

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

Specify:

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

SSI standard

Optional state supplement standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

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

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

Other

Specify:

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

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

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

The state does not establish reasonable limits.

The state establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(select one):

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

A percentage of the Federal poverty level

Specify percentage:

The following dollar amount:

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

The following formula is used to determine the needs allowance:

Specify formula:

Other

Specify:

300% of SSI

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

Select one:

- Allowance is the same
- Allowance is different.

Explanation of difference:

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

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

Select one:

- Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- The state does not establish reasonable limits.**
- The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: SSI State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is:

ii. Frequency of services. The state requires (select one):

The provision of waiver services at least monthly

Monthly monitoring of the individual when services are furnished on a less than monthly basis

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

Directly by the Medicaid agency

By the operating agency specified in Appendix A

By a government agency under contract with the Medicaid agency.

Specify the entity:

Other

Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the

educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Individuals performing initial assessments must have a minimum of six months of full-time experience in the field of IDD, and either a bachelor's degree or work experience in the field of Social Services, which may be substituted for the degree at the rate of 1040 hours of work experience for each semester of college.

KDADS may grant exceptions to the minimal requirements on an individualized basis. It is anticipated that the only exceptions that would be granted would be for persons who do not yet have the six months of experience in the IDD field. If the exception is granted, it will be given in writing from the KDADS IDD Program Manager to the CDDO responsible for that assessor.

An exception must be requested, in writing, from the CDDO to the KDADS IDD Program Manager. If this exception is granted, the assessor shall work under the direct supervision of a qualified assessor until the new assessor has had six months of experience. KDADS will maintain a log to track granted exceptions.

CDDO assessors performing reassessments must have a minimum of six months of full-time experience in the field of IDD, and either a bachelor's degree or work experience in the field of Social Services, which may be substituted for the degree at the rate of 1040 hours of work experience for each semester of college.

- d. Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The criteria for IDD program and functional eligibility are as follows:

1. Must be 5 years of age or older;
2. Have Intellectual Disability that began before the age of 18, and/or, have a diagnosis of a Developmental Disability that began before the age of 22;
3. Must be determined program eligible by the Community Disability Determination Organization;
4. Meet the Medicaid long-term care institutional threshold score using the State's functional eligibility instrument;
5. Be financially eligible for Medicaid
6. Be a resident of the State of Kansas

Programmatic Eligibility shall be conducted in accordance with the KDADS IDD HCBS Program Eligibility Policy. Functional eligibility shall be conducted in accordance with the KDADS Functional Eligibility Assessment and Waitlist Management Policy.

The Medicaid Functional Eligibility Instrument (MFEI) for Intellectual and Developmental Disability (MFEI-I/DD) is the tool that is used to determine functional eligibility for the IDD waiver. The tool is based on the interRAI-Home Care (IHC) tool with I/DD additions and the interRAI-Intellectual Disability (iID).

The MFEI-I/DD replaces the BASIS assessment which was based on the Developmental Disabilities Profile (DDP), which is no longer suitable for the waiver program.

The MFEI I/DD is the primary tool for determining functional eligibility for new assessments and current participant's reassessment.

- During the American Rescue Plan (ARP) Maintenance of Equity (MOE) period, KDADS will utilize a dual assessment approach. This means that both the BASIS and InterRAI-based assessments will still be in use.
 - o To ensure there is no disruption in waiver eligibility, scope, or duration of service during the transition period (ARP MOE Period) KDADS will reassess any current/active waiver participant found ineligible on the new InterRAI-based assessment (MFEI I/DD) using the previous (legacy) BASIS tool.
 - o If the legacy tool (the BASIS) finds the participant eligible, KDADS will sustain the functional eligibility of the participant.
 - o If participant is found ineligible with the MFEI I/DD and the BASIS, current waiver language regarding appeal rights will apply.
 - o This approach will extend throughout the ARP MOE Period.
 - o The Basic Assessment and Services Information System (BASIS) is the tool that is used to determine functional eligibility for the IDD waiver. Eligibility is based on the following categories Adaptive, Maladaptive, and Health. BASIS was previously referred to as the Developmental Disabilities Profile (DDP). BASIS and DDP are used interchangeably, and there is not a new eligibility tool.

The State also uses diagnostic documentation of a disability for initial eligibility.

- e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):

The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.

A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

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

evaluation process, describe the differences:

The CDDO or its eligibility subcontractor must provide conflict-free program and functional eligibility assessments. Under no circumstance can any employee of the CDDO or any employee of the subcontractor that conducts program or functional eligibility, also provide direct services or case management to the waiver participant.

Individuals presenting with reasonable indicators of meeting level of care eligibility are evaluated upon initial application for services, and then reevaluated within 365 days of their previous functional assessment, upon receiving waiver funding. The initial level of care assessment and reevaluation level of care assessment are the same. Reasonable indicators for initial eligibility requires diagnostic documentation of a disability.

Individuals performing functional assessments are CDDO employees. With prior written approval from KDADS, the CDDO may sub-contract out the screening, but under no circumstance can the sub-contractor also provide any direct service or case management to the waiver participant.

The assessment used evaluates the individual in three domains: medical, maladaptive, and adaptive. A variety of questions are answered in each domain and then the answers are formulated into a converted score. Results of the Level of Care Evaluation/Reevaluations are shared with the MCOs in order to create the Service Plan and to ensure that the participant's services are authorized according to current program and functional eligibility requirements.

KDADS Program staff reviews the individual programmatic and functional status documents. After the KDADS Program staff reviews all the information, they determine program eligibility. KDADS then submits the program eligibility status to the KDHE Eligibility Unit for KanCare Medicaid application financial consideration and final determination of eligibility for waiver services. KDHE sends the eligibility determination notice to the participant or responsible party. If not found eligible, the notice contains appeal rights. When an applicant is eligible, KDHE sends the completed ES-3160 form back to KDADS, the designated Managed Care Organization, and the CDDO.

- The MFEI I/DD is the primary tool for determining functional eligibility for new assessments and current participant's reassessment.
- During the American Rescue Plan (ARP) Maintenance of Equity (MOE) period, KDADS will utilize a dual assessment approach. This means that both the BASIS and InterRAI-based assessments will still be in use.
 - o To ensure there is no disruption in waiver eligibility, scope, or duration of service during the transition period (ARP MOE Period) KDADS will reassess any current/active waiver participant found ineligible on the new InterRAI-based assessment (MFEI I/DD) using the previous (legacy) BASIS tool.
 - o If the legacy tool (the BASIS) finds the participant eligible, KDADS will sustain the functional eligibility of the participant.
 - o If participant is found ineligible with the MFEI I/DD and the BASIS, current waiver language regarding appeal rights will apply.
 - o This approach will extend throughout the ARP MOE Period.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):

Every three months

Every six months

Every twelve months

Other schedule

Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations (*select one*):

The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.

The qualifications are different.

Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care (*specify*):

Requirements for timely reevaluations are a component of the State's contract with the CDDO. Both expectations and guidelines are specified in the Functional Eligibility Assessments and Waitlist Management Policy.

Assurance is provided through ongoing contract monitoring and quality reviews conducted by the State and/or MCO staff.

CDDOs have the ability to generate, from the State's assessment database, a report that gives a list of re-assessments that are due.

Re-evaluation due dates are generated upon submission of the completed assessment. Reassessments occur within 365 days and no earlier than 60 days prior to the reassessment due date.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Electronic documentation is kept by KDADS and written and/or electronically retrievable documents are also kept by the CDDO designated to perform level of care evaluations and reevaluations.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

a. Sub-assurance: *An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of newly enrolled waiver participants who were determined to meet LOC requirements prior to receiving HCBS services $N = \text{Number of newly enrolled waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services}$ $D = \text{Total number of newly enrolled waiver participants}$

Data Source (Select one):

Other

If 'Other' is selected, specify:

State Data Systems

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

and % of applicants identified with a reasonable indication that services may be needed in the near future that received a LOC eval N=# of applicants ident. with a reas. indication that services may be needed in the near future that received a LOC eval D=Total # of applicants ident. with a reas. indication that services may be needed in the near future that were reviewed Workplan= 7/1/25

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record Review

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =

		95% confidence level; +/- 5% margin of error
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/> Proportionate by MCO
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

b. Sub-assurance: *The levels of care of enrolled participants are reevaluated at least annually or as*

specified in the approved waiver.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

- c. Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of waiver participants whose Level of Care determinations used the State's approved screening tool N=Number of waiver participants whose Level of Care determinations used the State's approved screening tool D=Number of waiver participants who had a Level of Care determination reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =

		95% confidence level; +/- 5% margin of error
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/> Proportionate by MCO
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

These performance measures will be included as part of the comprehensive KanCare State Quality Improvement Strategy and assessed quarterly with follow remediation as necessary. In addition, the performance of the functional eligibility contractors will be monitored on an ongoing basis to ensure compliance with the contract requirements.

b. Methods for Remediation/Fixing Individual Problems

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

State staff and/or KanCare MCO staff request, approve, and assure implementation of provider corrective action planning and/or technical assistance to address non-compliance with waiver and performance standards as detected through on-site monitoring, survey results and other performance monitoring. These processes are monitored by both program managers and other relevant state and MCO staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy. Monitoring and survey results are compiled, trended, reviewed, and disseminated consistent with protocols identified in the statewide quality improvement strategy. Each provider receives annual data trending which identifies Provider specific performance levels related to statewide performance standards and statewide averages. Corrective Action Plan requests, technical assistance and/or follow-up to remediate negative trending are included in annual reports where negative trending is evidenced.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

For sub-assurance A, PM 2, the State will work with the assessing entities to determine the procedure for identifying reasonable indication for services. The State plans to implement this procedure in the 3rd quarter of 2025 and begin measuring the PM in the 4th quarter of 2025.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and
- ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Prior to the service plan development process, the participant's area CDDO informs eligible consumers, and/or their legal representatives, of feasible alternatives for long-term care, and documents their choice of either institutional or home and community-based waiver services.

This documentation ensures that K.A.R. 30-64-29 Gatekeeping requirements for information provision of all area services or supports available and rights pursuant to the DDRA are met.

Participants complete the IDD Medicaid Waiver Individual Choice form to indicate their choice of either Home and Community-Based services or services provided by an ICF-IID prior to their enrollment in either of these services. These forms are available to CMS upon request through the Medicaid agency or the operating agency.

Similarly, the KanCare MCO selected by the participant is responsible for providing or explaining the freedom of choice and "Participant Rights and Responsibilities" to the participant, parent or legal guardian. As part of the Person Centered Service Plan meeting the MCO Care Coordinator will review and gain signature from member or guardian the participant choice form and the Rights and Responsibilities form.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Copies are kept by the Community Developmental Disability Organization (CDDO) and by the persons or agencies designated as responsible for the performance of evaluations and reevaluations as indicated in contract.

Appendix B: Participant Access and Eligibility

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

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

KDADS has taken steps to assist staff in communicating with their Limited English Proficient Persons, and to meet the provisions set out in the Department of Health and Human Services Policy Guidance of 2000 requiring agencies which receive federal funding to provide meaningful access to services by Limited English Proficient Persons. In order to comply with federal requirements that participants receive equal access to services provided by KDADS and to determine the kinds of resources necessary to assist staff in ensuring meaningful communication with Limited English Proficient consumers, states are required to capture language preference information. This information is captured in the demographic section of the instrument. The State of Kansas defines prevalent non-English languages as languages spoken by significant number of potential enrollees and enrollees. Potential enrollee and enrollee materials will be translated into the prevalent non-English languages. Each contracted provider is required by Kansas regulation to make every reasonable effort to overcome any barrier that participants may have to receiving services, including any language or other communication barrier. This is achieved by having staff available to communicate with the participant in his/her spoken language, and/or access to a phone-based translation services so that someone is readily available to communicate orally with the consumer in his/her spoken language. (K.A.R. 30-60-15).

In addition, IDD waiver participants, as KanCare members, have access to comprehensive interpreter services via their chosen managed care organization.

Translation of all Medicaid documents are provided on request. The KanCare managed care organization contracts require that they demonstrate cultural competency and for organizations to provide information in several languages.

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

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	Day Supports		
Statutory Service	Overnight Respite Care		
Statutory Service	Personal Care Service (PCS)		
Statutory Service	Residential Supports		
Statutory Service	Supported Employment (SE)		
Supports for Participant Direction	Financial Management Services (FMS)		
Other Service	Children's Integrated Community Supports (CHICS)		
Other Service	Enhanced Care Service		
Other Service	Home and Environmental Modification Services (HEMS)		
Other Service	Medical Alert Rental		
Other Service	Specialized Medical Care		
Other Service	Specialized Medical Equipment and Supplies (SMES)		
Other Service	Vehicle Modification Services (VMS)		
Other Service	Wellness Monitoring		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

Day Supports

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04010 prevocational services

Category 2:

04 Day Services

Sub-Category 2:

04020 day habilitation

Category 3:

04 Day Services

Sub-Category 3:

04060 adult day services (social model)

Service Definition (Scope):

Category 4:

04 Day Services

Sub-Category 4:

04070 community integration

Day Supports are regularly occurring activities that provide a sense of participation, accomplishment, personal reward, personal contribution, or remuneration and thereby serve to maintain or increase adaptive capabilities, productivity, independence or integration and participation in the community. Support for volunteer work can be authorized under Day Supports.

Day Supports also includes the provision of pre-vocational services which are aimed at preparing a participant for paid or unpaid employment but are not job-task oriented. These services include teaching such concepts as compliance, attendance, task completion, problem solving and safety, as indicated in CFR 440.180.

These waiver services must be provided in person by licensed community service provider staff or a Shared Living Contractor.

Such activities shall be appropriate for or lead to a lifestyle as specified in the participant's person-centered support plan. These opportunities can include socialization, recreation, community inclusion, adult education, and skill development in the areas of employment, transportation, daily living, self-sufficiency, and resource identification and acquisition. These services may also be used to provide supported retirement activities, which may involve altering schedules to allow for more rest time during the day, support to participate in hobbies and other senior-related activities in their community.

Day Supports are provided in a variety of settings in the community at large. Services must be provided outside of the participant's residence unless the person has been determined frail or fragile and the provider has a signed statement from the participants' physician, advanced practice registered nurse or physician's assistant that receiving the supports outside the home would put the participants' health at risk. This day service provision must be approved by the KDADS IDD Program Manager in writing.

Participants eligible to receive services while they remain in the home must participate in activities consistent with their Person-Centered Support Plan and to the extent possible, replicate activities in which the person would be participating if they were out of the home. Documentation of those activities must be maintained and provided upon request for review by the CDDO, MCO, KDADS and KDHE.

Virtual delivery of a service is an electronic method of service delivery. The purpose of virtual delivery of a service is to maintain or improve a participant's functional abilities, enhance interactions, support meaningful relationships, and meaningfully participate in their community. Virtual delivery of services may be a service option to provide independence in licensed group homes, therapies or agency-directed personal care services. The participant should have other opportunities for integration in the community via other services the participant receives.

Virtual Delivery of a service shall mean the provision of services through equipment with the capability for live real-time audio-visual connection that allows the staff member to both see and hear the participant. Text messaging and e-mailing do not constitute virtual services and, therefore, will not be considered provision of direct services under specified HCBS Services.

Direct service can be provided through the virtual delivery of the service when all of the following requirements are met:

- a. The virtual delivery of the service ensures the participant's rights of privacy, dignity and respect, and freedom from coercion and restraint.
- b. The virtual delivery of the service does not isolate the participant from the community or interacting with people without disabilities.
- c. The virtual delivery of the service has been agreed to by the participant and their team and outlined in the Person-Centered Plan;
 - i. Participants must have an informed choice between in person or the virtual delivery of the service;
 - ii. The virtual delivery of a service cannot be the only service delivery provision for a participant seeking the given service; and
 - iii. Participants must affirmatively choose virtual delivery of the service over in-person services.
- d. Virtual delivery of a service is not, and will not be, used for the provider's convenience. The virtual delivery of the service must be used to support a participant to reach identified outcomes in the participant's Person-Centered Plan;
- e. Virtual delivery of a service must be documented appropriately as any other service being delivered, including start and end times.
- f. The virtual delivery of a service must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations to protect the privacy and security of the participant's

protected health information.

g. Virtual delivery of a service, including using phones, cannot be used to assess a participant for a medical emergency. The provider must develop and maintain written policies, train direct support staff on those policies, and advise participants and their person-centered planning team regarding those policies that address:

h. Identifying individuals to intervene (such as uncompensated caregivers present in the participant's home), and ensuring they are present during provision of virtual delivery of the service in case the participant experiences an emergency; and processes for requesting such intervention if the participant experiences an emergency during provision of virtual services, including contacting 911 if necessary.

i. The virtual services meets all federal and State requirements, policies, guidance, and complies with 42 CFR 442.301 (c)(4)(vi)(A) through (D) related to privacy, control of schedule, activities, and access to visitors.

j. Providers furnishing a HCBS waiver service via virtual delivery of service must include virtual delivery of a service in their provider Program Service Plan prior to implementing.

k. The provider must develop, maintain, and enforce written policies, approved by the MCO, which address:

i. Identifying whether the participant's needs, including health and safety, can be addressed safely via virtual delivery of the service.

ii. How the provider will ensure the participant's rights of privacy, dignity and respect, and freedom from coercion and restraint during virtual delivery of the service.

iii. How the provider will ensure the virtual delivery of the service meets applicable information security standards; and

iv. iv. How the provider will ensure the provision of virtual delivery of the service complies with applicable laws governing individuals' right to privacy.

Instances, Instructions and Limitations

Virtual Delivery of a service will only be authorized when a waiver participant requests the service to be delivered virtually and the technology or device appropriate to support the virtual delivery of the service is available.

Instructions and Limitations

- The program participant's person-centered service plan must indicate the use of the virtual delivery of the service.
- The managed care organization must document the frequency of the virtual delivery of the service.
- The provider must also document and track how the service is delivered. Documentation must be done in the same manner as if it was delivered in person.
- Virtual delivery of a service shall be provided in real-time, not via a recording.
- When virtual delivery of the service is provided, the provider shall only render the service on a one-on-one/individualized basis.
- The service provider shall be responsible for providing the device or technology required to support the virtual delivery of the service. The Waiver program will not fund any costs associated with the provider's virtual delivery of the service such as obtaining, installing, and implementing equipment, internet, software applications, and other related expenses. These costs, in the virtual delivery of the service are part of the provider's operating costs.

Technology and Devices

- Virtual delivery of a service may leverage the existing technologies or devices belonging to the waiver participant.
- HCBS waiver funding shall NOT be used to purchase technologies or devices or internet connectivity for the primary purpose of virtual delivery of a service.
- The provider shall be responsible for the maintenance, upkeep and assurance the device is in working order.

Community Integration and Participant's Choice

- Where virtual delivery of a service is requested by the participant and authorized by the managed care organization, the following requirements shall be met to ensure the delivery method does not lead to isolating or regimenting the participant from the greater community.
 - o The virtual delivery of the service shall be provided in the participant's preferred setting.
 - The participant's choice for virtual delivery of a service shall be documented and included in their service plan.
 - o The participant shall be able to rescind their choice of virtual delivery of a service at any time.

When this occurs, the MCO shall ensure service continuity via a non-virtual delivery method and confirm that the participant's service plan reflects the participant's choice change.

- o The managed care organization shall be responsible for ensuring that the provider is educating and informing the participant on the scope of the virtual delivery of the service prior to documenting the choice of the individual.
- o The physical location where virtual services are provided, as well as the activities rendered as part of the service are monitored through KDADS licensing as well as the MCO.

Training Requirement

- Where virtual delivery of a service is requested by the participant and authorized by the managed care organization, the provider shall train the participant to use the solution or application and device (where a new device is provided).
- Training for the participant and staff must demonstrate trainees understands how the virtual services will ensure the participant's health, welfare, and independence.
- Training must demonstrate that staff and participant have the competency after training to successfully utilize the technology.
 - o The training should assist the participant in attaining the knowledge required to operate technologies that facilitate successful virtual delivery of the service.
 - o Staff training on the technology that will be utilized for the person in service. must be person-specific, mode of technology utilized for the participant. Training for both participant and staff must be documented with a plan for continuing education on the technology for participant and staff.

Units and delivery for virtual delivery is found in Main 8 B.

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

A. IDD Day Supports shall NOT be authorized for anyone who is an inpatient of a hospital, a nursing facility, or an ICF-IID.

B. Participants eligible for services through the local education authority cannot be reimbursed with IDD waiver funds unless the participant is at least 18 years of age, is graduating from high school before the age of 22, and not receiving a similar service through an Individual Education Plan (IEP). To be reimbursed IDD waiver funds, a transition plan must be in place and available upon request that includes employment options. The transition plan can be within the IEP or other documentation methods. The CDDO will provide service options, which shall include employment as an option, upon request, or at least annually.

C. Day Supports for adults are provided for individuals 18 years of age or older.

D. To be reimbursed for Day Services, participants must be out of their home unless one of the following applies:

1. a participant operates a home-based business, or;
2. An exception request has been submitted due to participant's medical necessity or other extenuating circumstances, as described below.
3. Participants that have been granted an exception to receive Day Supports in the participant's home must participate in activities that are consistent with the participant's Person-Centered Service Plan, and the Day Supports provided must replicate the services which would normally occur outside of the home.
4. If a participant prefers to receive Day Supports outside the home less than five days per week, his/her preference and assessed need for Day Supports must be documented in the Person-Centered Service Plan.

E. To avoid overlap of services, Day Support is limited to those services not covered through the Medicaid State Plan or other HCBS services and which cannot be procured from other formal or informal resources. Waiver funding shall be the funding source of last resort and requires prior authorization from the MCO via the participant's Person-Centered Service Plan.

1. Pre-vocational services cannot duplicate services funded under the Rehabilitation Act of 1973 or under the provisions of the Individuals with Disabilities Education Act (IDEA).

2. Day Supports cannot bill for services that are described in the definition, scope and limitations of Supportive Employment.

F. Day Supports are an agency-directed only service.

G. In any given month, the maximum number of reimbursable units of Day Supports is 460 units. The maximum number of reimbursable units of Day Supports during the providers' defined seven-day week is 100 units. The maximum number of reimbursable units of Day Supports for any given day is 32 units.

Per the KanCare contracts the MCOs are responsible for ensuring the individual's needs are met with a combination of waiver, State Plan, and community resources. The MCO would ensure via the Person-Centered Service Plan and monitoring of the plan that the needs of the participant are being met.

Exception request process for Day Supports provided in the home:

1. Prior to providing the day supports in the home, the provider must request an exception through the CDDO. After review and approval by the CDDO, the CDDO shall send the request to KDADS.

2. Each CDDO-approved inclement weather request sent to KDADS shall include the provider completed KDADS' template for each participant requiring this exception.

3. Exceptions can be requested under the following circumstances: medical necessity, home-based business or inclement weather.

4. Documentation Requirements for medical necessity include: a physician, advanced practice registered nurse or physician's assistant, signed statement on letterhead issued within the past 6 months, Person-Centered Support Plan, and the Person-Centered Service Plan.

5. Documentation requirements for home-based business include: a description of the person's home-based business, Person-Centered Support Plan, and the Person-Centered Service Plan.

6. Documentation requirements and the process for requesting and exception due to inclement weather are detailed in the KDADS Inclement Weather policy 2013-02-01.

7. The documents shall be provided to the KDADS IDD Program Manager for review and either approval or denial of the in-home day support exception.

8. If the exception request is for an acute medical necessity that has a likelihood of recovery for the Participant and is signed by a physician, advanced practice registered nurse or physician's assistant, or is a home-based business, the exception will be reviewed by KDADS every six (6) months.

9. If the exception is due to medical frailty necessity, it will require a physician, advanced practice registered nurse or physician's assistant statement signed by a physician, advanced practice registered nurse or physician's assistant

on letterhead that describes the participant's current medical and physical condition and likelihood of recovery.
 10. For the medical frailty exception, if the condition is chronic and the likelihood of recovery is low, the request shall be submitted every two years for review by the CDDO, the MCO, and KDADS.

Service Delivery Method *(check each that applies):*

- Participant-directed as specified in Appendix E**
- Provider managed**

Specify whether the service may be provided by *(check each that applies):*

- Legally Responsible Person**
- Relative**
- Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Community Service Providers

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Supports

Provider Category:

Agency

Provider Type:

Licensed Community Service Providers

Provider Qualifications

License *(specify):*

Licensed by KDADS consistent with K.A.R. 30-63-01 through 30-63-32.

Certificate *(specify):*

Other Standard *(specify):*

All HCBS providers are required to pass background checks consistent with the KDADS' Background Check policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have been substantiated for a prohibited offense as listed in K.S.A. 39-2009 is not eligible for reimbursement of services under Medicaid funding.

Consistent with the DDRA, Providers:

*Must submit policies and procedures for KDADS approval.

*All staff must be trained Abuse, Neglect, and Exploitation and staff who administer medications to Participants must be trained in medication administration.

Providers must be enrolled in KMAP; and must either contract with a KanCare MCO or be an approved out-of-network provider with a KanCare MCO.

Providers must be affiliated with the CDDO for each area in which the services will be provided.

Verification of Provider Qualifications

Entity Responsible for Verification:

Managed Care Organizations in accordance with the Provider Qualification policy M2017-171.

Frequency of Verification:

The MCOs, with oversight by KDADS, shall verify provider qualifications annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Overnight Respite Care

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08030 personal care

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Overnight Respite Care is designed to provide relief for the participant's family member who serves as an unpaid primary caregiver. Respite is necessary so unpaid, primary caregivers are able to receive periods of relief for vacations, holidays and scheduled periods of time off. Overnight Respite Care is provided in planned segments and includes payment during the participant's sleep time.

A self-direct option may be chosen for Overnight Respite by the participant if the participant is not a child in DCF custody living in a licensed foster care setting. If the participant is not capable of providing self-direction, the participant's guardian, or legally appointed representative shall choose.

Overnight Respite Care may be provided in the following location(s):

- *Participant's family home or place of residence;
- *Licensed Foster Home;
- *Facility approved by KDHE or KDADS which is not a private residence, or;
- *Licensed Respite Care Facility/Home.

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

Overnight Respite care may not be provided by a participant's spouse, by a parent of a participant who is a minor child under eighteen years of age, or by the unpaid primary caregiver.

Court appointed guardians and conservators shall not be paid to provide waiver services unless all potential conflicts of interest have been mitigated as per K.S.A. 59-3068.

1. The court appointed guardian is responsible to report any potential conflicts to the court in the annual or special report per guardianship law and to maintain documentation of the court determination.

2. In order to be paid to provide PCS to the participant, the court appointed guardian shall provide the special or annual report copy disclosing the conflict of interest and the judge's approval order of said report, plus determination of no guardian conflict of interest to the MCO and FMS provider.

3. If the court determines that all potential conflict of interest concerns are not mitigated, the legal guardian can:

a. Pick someone else to provide the HCBS services to the participant. The participant's MCO or FMS provider may assist the legal guardian to find a support worker, or to seek other HCBS service providers in the community;

OR

b. Appoint someone as a Designated Representative to develop and direct the participant's HCBS Person Centered Service Plan.

4. An activated durable power of attorney is not permitted to be a paid provider for participant unless a Designated Representative is appointed to direct the participant's care and workers.

5. An exception to the criteria may be granted by the MCO when a participant/guardian lives in a rural setting and the nearest agency-directed service provider available to provide services is in excess of 50 miles from the participant residence or the location is so remote that HCBS Program Services would otherwise not be available. For waiver purposes, relatives are defined as parents of minors, and spouses of waiver participants. PCS may be used to pay parents or participant's spouse. Parents of minors and spouses must meet the provider qualifications for PCS.

To avoid overlap of services, Overnight Respite is limited to those services not covered through the Medicaid State Plan or other HCBS services and which cannot be procured from other formal or informal resources. Waiver funding shall be the funding source of last resort and requires prior authorization from the MCO via the participant's Person-Centered Service Plan.

1. Participants who receive Overnight Respite Care services may not also receive Residential Supports or Personal Care Services as an alternative to Overnight Respite.

2. The KanCare MCOs will not allow payment for claims for both Overnight Respite Care and Enhanced Care Services on the same dates of service.

Overnight Respite Care services cannot be provided to an individual who is an inpatient of a hospital, a nursing facility, or an ICF-IID when the inpatient facility is billing Medicaid, Medicare and/or private insurance.

Room and board is not part of the cost of service unless provided as part of respite care in a facility approved by the state that is not a private residence.

A maximum of 60 nights of Overnight Respite per calendar year is allowed. Overnight Respite is billed on a daily rate (one unit equals one day).

Children receiving care in licensed foster care settings do not have the option to self-direct services and must be provided through the agency-directed service model, unless an exception has been granted.

Per the KanCare contracts the MCOs are responsible for ensuring the participant's needs are met with a combination of waiver, State Plan, and community resources. The MCO would ensure via the Person-Centered Service Plan and monitoring of the plan that the needs of the participant are being met.

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Overnight Respite Provider
Individual	Overnight Respite Care Provider

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Overnight Respite Care

Provider Category:

Agency

Provider Type:

Overnight Respite Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Must be affiliated with the CDDO for the area in which they operate.

All HCBS providers are required to pass background checks consistent with the KDADS' Background Check policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have been substantiated for a prohibited offense as listed in K.S.A .39-2009 is not eligible for reimbursement of services under Medicaid funding.

Consistent with the DDRA, providers:
 *Must submit policies and procedures for KDADS' approval
 *All staff must be trained Abuse, Neglect, and Exploitation and staff who administer medications to Participants must be trained in medication administration.

Providers must also enroll in KMAP; and must either contract with a KanCare MCO or be an approved out-of- network provider with a KanCare MCO.

Provider must be an affiliate of the CDDO in the area in which the services will be provided.

Verification of Provider Qualifications

Entity Responsible for Verification:

Managed Care Organizations in accordance with the Provider Qualification policy M2017-171.

Frequency of Verification:

The MCOs, with oversight by KDADS, shall verify provider qualifications annually.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Overnight Respite Care

Provider Category:

Individual

Provider Type:

Overnight Respite Care Provider

Provider Qualifications

License (specify):

[Empty text box for license specification]

Certificate (specify):

[Empty text box for certificate specification]

Other Standard (specify):

All HCBS providers are required to pass background checks consistent with the KDADS' Background Check policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have been substantiated for a prohibited offense as listed in K.S.A. 39-2009 is not eligible for reimbursement of services under Medicaid funding.

Verification of Provider Qualifications

Entity Responsible for Verification:

Managed Care Organizations in accordance with the Provider Qualification policy M2017-171.

Frequency of Verification:

The MCOs, with oversight by KDADS, shall verify provider qualifications annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Personal Care Service (PCS)

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08030 personal care

Category 2:

09 Caregiver Support

Sub-Category 2:

09012 respite, in-home

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

PCS are one-to-one, individualized services provided during times when the participant is not typically sleeping, as self-directed (SD) or agency-directed (AD) supports. PCS hours are directly related to ADLS and IADLS which are provided when a participant is awake. If exceptions are needed to cover needs medical in nature, an exception needs to be present. Exceptions can be made to ensure the health and safety of the participant.

PCS services can be delivered in a hospital setting per Section 3715 of the CARES Act, PL116-136 to support participants with ADLs and IADLs. Services cannot be duplicative of services provided by the hospital.

Scope, duration, and amount of services authorized by the MCO shall be consistent with the participant's assessed need as documented in the Person-Centered Service Plan (service plan). PCS includes support to participants in the following areas:

1. Activities of Daily Living (ADLs)
2. Health maintenance activities (HMA) in accordance with the Personal Care Services and Limitations policy.
3. Instrumental Activities of Daily Living (IADLs)
4. Supervision: health, safety and welfare of non-foster care participants
5. Assistance and accompaniment: exercise, socialization, recreation activities
6. Assistance accessing medical care, including to assist during medical and therapeutic appointments as listed in the participant's service plan.

The State delegates to the MCOs the management of agency direct listings to be provided to participants as each MCO could differ in contracted entities and the most up-to-date listing can be provided by the participant's MCO.

PCS must:

- Meet the definition of PCS as outlined in the federal waiver plan.
- be specified in the participant's Service Plan
- be provided by a person who meets the necessary identified qualifications and training standards in the participant's Service Plan;
- Complete training from the participant or their representative via the PCS checklist developed by the participant and/or their representative and aided by their Care Coordinator as necessary. This document will be in kept in the participant's home, be part of the Service Plan, and reviewed at least annually and updated as needed to indicate change in the participant's service needs.

Virtual Delivery PCS is available for agency-directed PCS only.

Virtual delivery of a service (VDS) is an electronic method of service delivery. The purpose of virtual delivery of a service is to maintain or improve a participant's functional abilities, enhance interactions, support meaningful relationships, and meaningfully participate in their community.

The participant must have other opportunities for integration in the community via other services the participant receives.

VDS shall mean the provision of supports through equipment with the capability for live real-time audio-visual connection that allows the staff member to both see and hear the participant.

Direct support can be provided through the virtual delivery of the service when all of the following requirements are met:

- a. The virtual delivery of the service ensures the participant's rights of privacy, dignity and respect, and freedom from coercion and restraint.
- b. The virtual delivery of the service does not isolate the participant from the community or interacting with people without disabilities.
- c. The virtual delivery of the service has been agreed to by the participant and their team and outlined in the Person-Centered Service Plan;
 - i. Participants must have an informed choice between in person or the virtual delivery of the service;
 - ii. The virtual delivery of a service cannot be the only service delivery provision for a participant seeking the given service; and
 - iii. Participants must affirmatively choose virtual delivery of the service over in-person supports.
- e. VDS is not and shall not be used for the provider's convenience. The virtual delivery of the service shall be used to support a participant to reach identified outcomes in the participant's service plan;
- f. Virtual delivery of a service must be documented appropriately as any other service being delivered, including start and end times.
- g. The virtual delivery of a service must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations to protect the privacy and security of the participant's protected health information.
- h. VDS, including using phones, cannot be used to assess a participant for a medical emergency. The provider must

develop and maintain written policies, train direct support staff on those policies, and advise participants and their person-centered planning team regarding those policies that address:

- i. Identifying individuals to intervene (such as uncompensated caregivers present in the participant's home), and ensuring they are present during provision of virtual delivery of the service in case the participant experiences an emergency; and processes for requesting such intervention if the participant experiences an emergency during provision of virtual supports, including contacting 911 if necessary.
- j. The virtual supports meets all federal and State requirements, policies, guidance, and regulations.
- k. Providers furnishing this Waiver program service via virtual delivery of service must include virtual delivery of a service in their provider Program Service Plan prior to implementing.
- l. The provider must develop, maintain, and enforce written policies, approved by the state, which address:
 - i. Identifying whether the participant's needs, including health and safety, can be addressed safely via virtual delivery of the service.
 - ii. How the provider will ensure the participant's rights of privacy, dignity and respect, and freedom from coercion and restraint during virtual delivery of the service.
 - iii. How the provider will ensure the virtual delivery of the service meets applicable information security standards; and
 - iv. How the provider will ensure the provision of virtual delivery of the service complies with applicable laws governing individuals' right to privacy.

Instances, Instructions, and Limitations

- The participant's service plan must indicate the use of the virtual delivery of the service.
- The MCO must document the frequency of the virtual delivery of the service.
- When virtual delivery of the service is provided, the provider shall only render the service or support on a one-on-one/individualized basis.
- VDS may leverage the existing technologies or devices belonging to the waiver participant.
- The provider shall be responsible for the maintenance, upkeep and assurance the device is in working order.
- Where virtual delivery of a service is requested by the participant and authorized by the MCO, the following requirements shall be met to ensure the delivery method does not lead to isolating or regimenting the participant from the greater community.

The virtual delivery of the service shall be provided in the participant's preferred setting.

- The participant's choice for virtual delivery of a service shall be documented and included in their service plan. The participant shall be able to rescind their choice of virtual delivery of a service at any time.

When this occurs, the MCO shall ensure service continuity via a non-virtual delivery method and confirm that the participant's service plan reflects the participant's choice change.

The MCO shall be responsible for ensuring that the provider is educating and informing the participant on the scope of the virtual delivery of the service prior to documenting the choice of the individual.

- Where virtual delivery of a service is requested by the participant and authorized by the MCO, the provider shall train the participant to use the solution or application and device (where a new device is provided).

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

Units and delivery for virtual delivery is found in Main 8 B

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

The service must occur in the home or community location meeting the setting requirements as defined in the HCBS Setting Final Rule.

The services under the IDD Waiver are limited to additional services not otherwise covered under the state plan, including Early and Periodic Screening, Diagnosis and Treatment (EPSDT), but consistent with waiver objectives of avoiding institutionalization.

Personal Care Services provided in a home school setting must not be educational in purpose.

PCS cannot be provided in a school setting and cannot be used for education, as a substitute for educationally related services as outlined in the participant's Individualized Education Program (IEP)

Services furnished to an individual who is an inpatient or resident of a hospital (unless an exception is granted), nursing facility, intermediate care facility for persons with Intellectual Disability (ICF-IID), or Institution for Mental disease are not covered.

PCS will be coordinated by the KanCare MO Care Manager and arranged for and purchased under the participant or legally responsible party's written authority, consistent with and not exceeding the participant's authorized service plan. Self-Directed PCS will be paid through an enrolled FMS agency.

A PCS worker may not perform any duties not delegated by the participant or participant's representative with the authority to direct services or duties as approved by the participant's physician. The PCS worker's task(s) must be identified as an authorized task or tasks as per the participant's authorized person-Center Service Plan and approved Person-Centered Support Plan.

The services under the IDD waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. PCS is limited to those services which cannot be procured from other formal or informal resources. Waiver funding shall be the funding source of last resort and requires prior authorization from the MCO via the participant's Person-Centered Service Plan.

Service plans for which it is determined that the provisions of PCS would be a duplication of service will not be approved.

PCS worker cannot perform any duties for the participant that would otherwise be consistent with the Supported Employment definition.

PCS shall not be authorized for the times a participant has Residential or Day supports authorized in the participant's Person-Centered Service Plan.

Participants receiving Residential supports cannot also receive PCS as an alternative for the same Residential supports, or any of the family/individual supports. This does not prevent the conversion of Day Supports to PCS. Participants receiving Day supports cannot also receive PCS as an alternative for the same Day Supports. This does not prevent the conversion of Day supports to PCS.

PCS being provided as a self-directed alternative to Residential or Day supports cannot be provided by the legal guardian of the participant.

Prevocational, educational services, or supported employment services available to the participant through a local educational agency under the Individuals with Disabilities Act (IDEA) or the Rehabilitation Act of 1973 are not covered.

Participants in Residential Supports cannot also receive PCS, Enhanced Care Services, or Overnight Respite Care.

Personal Care Services are limited to the assessed level of service need, as specified in the Person-Centered Service Plan, up to 12 hours per 24-hour day. The need to exceed the maximum service limit is subject to approval by the participant's MCO.

The MCO may authorize services exceeding the 12 hours per 24-hour day accommodation if the participant meets one or more of the following criteria:

1. The additional request for PCS is critical to the remediation of the participant's abuse neglect, exploitation, or domestic violence issue.
2. The additional request for PCS is critical to the participant's ability to remain in the community in lieu of an institution.
3. The time additional request for PCS is a necessary support for the participant to return to the community from an institutional setting.

All Personal Care Services will be arranged for, reviewed, and approved by the KanCare MCO's Care Coordinator with the participant's written authorization, & paid for through an enrolled home health agency, when services are agency-directed, or an enrolled Financial Management Service (FMS) provider, when services are participant-directed. Payment for services must be made within the minimum approved reimbursement established by the state. A person may have several PCS workers providing him/her care on a variety of days at a variety of times, but a person may not have more than one PCS worker providing care at any given time, unless the need for an additional

PCS worker is necessary to meet the health and welfare needs of the participant. Children receiving care in licensed foster care settings do not have the option to self-direct services unless established exception criteria are met. Unless otherwise approved by KDADS, all services must be provided through the agency-directed service model.

Personal Care Services identified in a participant's Person Centered-Support Plan that are not met through the provision of hospital services and/or designed to ensure smooth transitions between acute care settings and home and community-based settings, and to preserve the individual's functions may be provided in an acute hospital to the participant by their Personal Care Worker. Personal Care Services are not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement.

Service Delivery Method *(check each that applies):*

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies):*

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency
Individual	Individual Personal Assistants

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Personal Care Service (PCS)

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Home Health Agency License

Employees of a Home Health Agency as specified in K.S.A. 65-5101 through K.S.A. 65-5117.

Certificate *(specify):*

Other Standard *(specify):*

Providers must be affiliated with the CDDO in the area in which the services will be provided. Providers must enroll in KMAP and must either contract with a KanCare MCO or be an approved out-of-network provider with a KanCare MCO.

All HCBS providers are required to pass background checks consistent with the KDADS' Background Check policy and comply with all regulations related to Abuse, Neglect, and Exploitation. Any provider found to have a prohibited offense, as listed in K.S.A. 39-2009, is not eligible for reimbursement of services under Medicaid funding.

PCS provider workers must be at least 18 years of age or have at least a high school diploma or GED. Workers who are siblings to the participant receiving PCS services must be at least 18 years old.

Agency-Directed PCS workers:

1. An attendant who is a certified home health aide or certified nurse aide shall not perform any health maintenance activities without delegation and supervision of a nurse or physician pursuant to K.S.A. 65-1165.
 2. A certified home health aide or certified nurse aid shall not perform acts beyond the scope of their curriculum without delegation by a licensed nurse.
 3. An agency shall maintain documentation of delegation by a licensed physician or nurse not employed by the agency. Agencies are responsible for ensuring appropriate supervision of delegated health maintenance activities.
 4. Failing to properly supervise, direct, or delegate acts that constitute the healing arts to persons who perform professional services pursuant to such licensee's direction, supervision, order, referral, delegation or practice protocols could result in discipline by the Board of Healing Arts.
- Agency-directed service provision shall comport with KDADS Personal Care Services and Limitations policy.

Verification of Provider Qualifications

Entity Responsible for Verification:

Managed Care Organizations in accordance with the Provider Qualification policy M2017-171.

Frequency of Verification:

The MCOs, with oversight by KDADS, shall verify provider qualifications annually.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Personal Care Service (PCS)

Provider Category:

Individual

Provider Type:

Individual Personal Assistants

Provider Qualifications

License (specify):

[Empty text box for license specification]

Certificate (specify):

[Empty text box for certificate specification]

Other Standard (*specify*):

Providers must be at least 16 years of age, or at least 18 years of age if a sibling of the waiver participant, unless an exception to this requirement has been granted in writing by the commission, based upon the needs of the person receiving services, per K.A.R. 30-63-10 (4)(F)

Providers are required to pass background checks consistent with the KDADS' Background Check policy and comply with all regulations related to Abuse, Neglect and Exploitation.

Any provider found to have a prohibited offense, as listed in K.S.A. 39-2009, is not eligible for reimbursement of services under Medicaid funding.

Consistent with K.A.R. 30-63-10, the participant is responsible for documenting that the individual provider has received sufficient training to provide the needed service. That documentation must be provided to the CDDO.

All PCS assistants must be enrolled with an enrolled Financial Management Services (FMS) provider who is also an affiliate of the CDDO in the area in which the service will be provided.

Verification of Provider Qualifications

Entity Responsible for Verification:

Managed Care Organizations in accordance with the Provider Qualification policy M2017-171.

Frequency of Verification:

The MCOs, with oversight by KDADS, shall verify provider qualifications annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

Residential Supports

HCBS Taxonomy:

Category 1:

02 Round-the-Clock Services

Sub-Category 1:

02011 group living, residential habilitation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

08 Home-Based Services

08010 home-based habilitation

Service Definition (Scope):

Category 4:

Sub-Category 4:

Adult Residential Supports are provided to participants who live in a residential setting and do not live with their birth or adoptive parents, or with a person meeting the definition of family, unless that family member is receiving IDD waiver services or on the waitlist for IDD waiver services. Family is defined as any person immediately related to the participant, such as parents/legal guardian, spouse, siblings, adult children, aunts, uncles, first cousins and any step-family relationships.

This service provides assistance with and acquisition, retention and/or improvement of skills related to activities of daily living such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting.

Adult Residential Supports may be provided in one of the following ways:

1.a participant lives in his or her own home or apartment without an individual meeting the definition of family, unless that family member is receiving IDD waiver services or on the waitlist for IDD waiver services, or a service provider

2.a participant lives in his or her own home or apartment with other individuals who do not meet the definition of family, unless that family member is receiving IDD waiver services or on the waitlist for IDD waiver services, or a service provider

Adult Residential Supports may be provided in their own home, a licensed Group Home, Shared Living Setting.

Children's Residential Supports provide direct assistance to participants in order to meet their daily living situation and serve to maintain or increase adaptive capabilities, independence, integration and participation in the community.

Children's Residential supports are for children who are not in the custody of DCF and who are between the ages of 5 and 21. Access to these services end on the participant's 22nd birthday.

These services are designed to avoid placement in an institution, congregate residential setting or DCF custody when the participant cannot remain in their natural family home.

These services are provided outside the family home in a home which:

1.Is licensed by KDHE as a family foster home, meets all State or KDADS requirements, or is another residential setting that is approved in writing by KDADS.

2.Serves no more than two (2) children unrelated to the waiver participant, unless an exception has been granted, and;

3.Is located in or near the child's home community and school so the child remains in contact with the natural family, if appropriate, and maintains established community connections such as the child's school and teachers, friends and neighbors, community activities, church and health care professionals.

4.Is compliant with the HCBS Settings Final Rule.

Children's Residential providers must also cooperate with the MCO, the CDDO, the school district, and any consultants in designing and implementing specialized training procedures for the participant. They must also actively participant participate in IEP development and the public-school education program, as well in the Person-Centered Support Planning and Person-Centered Service Planning processes for the participant.

Virtual delivery of a service is an electronic method of service delivery. The purpose of virtual delivery of a service is to maintain or improve a participant's functional abilities, enhance interactions, support meaningful relationships, and meaningfully participate in their community. Virtual delivery of services may be a service option to provide independence in licensed group homes, therapies or agency-directed personal care services. The participant should have other opportunities for integration in the community via other services the participant receives.

Virtual Delivery of a service shall mean the provision of services through equipment with the capability for live real-time audio-visual connection that allows the staff member to both see and hear the participant. Text messaging and e-mailing do not constitute virtual services and, therefore, will not be considered provision of direct services under specified HCBS Services.

Direct service can be provided through the virtual delivery of the service when all of the following requirements are met:

a. The virtual delivery of the service ensures the participant's rights of privacy, dignity and respect, and freedom from coercion and restraint.

b. The virtual delivery of the service does not isolate the participant from the community or interacting with people without disabilities.

c. The virtual delivery of the service has been agreed to by the participant and their team and outlined in the Person-Centered Plan;

i. Participants must have an informed choice between in person or the virtual delivery of the service;

- ii. The virtual delivery of a service cannot be the only service delivery provision for a participant seeking the given service; and
- iii. Participants must affirmatively choose virtual delivery of the service over in-person services.
- d. Virtual delivery of a service is not, and will not be, used for the provider's convenience. The virtual delivery of the service must be used to support a participant to reach identified outcomes in the participant's Person-Centered Plan;
- e. Virtual delivery of a service must be documented appropriately as any other service being delivered, including start and end times.
- f. The virtual delivery of a service must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations to protect the privacy and security of the participant's protected health information.
- g. Virtual delivery of a service, including using phones, cannot be used to assess a participant for a medical emergency. The provider must develop and maintain written policies, train direct support staff on those policies, and advise participants and their person-centered planning team regarding those policies that address:
 - h. Identifying individuals to intervene (such as uncompensated caregivers present in the participant's home), and ensuring they are present during provision of virtual delivery of the service in case the participant experiences an emergency; and processes for requesting such intervention if the participant experiences an emergency during provision of virtual services, including contacting 911 if necessary.
 - i. The virtual services meets all federal and State requirements, policies, guidance, and complies with 42 CFR 442.301 (c)(4)(vi)(A) through (D) related to privacy, control of schedule, activities, and access to visitors.
 - j. Providers furnishing a HCBS waiver service via virtual delivery of service must include virtual delivery of a service in their provider Program Service Plan prior to implementing.
 - k. The provider must develop, maintain, and enforce written policies, approved by the MCO, which address:
 - i. Identifying whether the participant's needs, including health and safety, can be addressed safely via virtual delivery of the service.
 - ii. How the provider will ensure the participant's rights of privacy, dignity and respect, and freedom from coercion and restraint during virtual delivery of the service.
 - iii. How the provider will ensure the virtual delivery of the service meets applicable information security standards; and
 - iv. How the provider will ensure the provision of virtual delivery of the service complies with applicable laws governing individuals' right to privacy.

Instances

Virtual Delivery of a service will only be authorized when a waiver participant requests the service to be delivered virtually and the technology or device appropriate to support the virtual delivery of the service is available.

Instructions and Limitations

- The program participant's person-centered service plan must indicate the use of the virtual delivery of the service.
- The managed care organization must document the frequency of the virtual delivery of the service.
- The provider must also document and track how the service is delivered. Documentation must be done in the same manner as if it was delivered in person.
- Virtual delivery of a service shall be provided in real-time, not via a recording.
- When virtual delivery of the service is provided, the provider shall only render the service on a one-on-one/individualized basis.
- The service provider shall be responsible for providing the device or technology required to support the virtual delivery of the service. The Waiver program will not fund any costs associated with the provider's virtual delivery of the service such as obtaining, installing, and implementing equipment, internet, software applications, and other related expenses. These costs, in the virtual delivery of the service are part of the provider's operating costs.

Technology and Devices

- Virtual delivery of a service may leverage the existing technologies or devices belonging to the waiver participant.
- HCBS waiver funding shall NOT be used to purchase technologies or devices or internet connectivity for the primary purpose of virtual delivery of a service.
- The provider shall be responsible for the maintenance, upkeep and assurance the device is in working order.

Community Integration and Participant's Choice

- Where virtual delivery of a service is requested by the participant and authorized by the managed care

organization, the following requirements shall be met to ensure the delivery method does not lead to isolating or regimenting the participant from the greater community.

- o The virtual delivery of the service shall be provided in the participant's preferred setting.
- The participant's choice for virtual delivery of a service shall be documented and included in their service plan.
- o The participant shall be able to rescind their choice of virtual delivery of a service at any time.

When this occurs, the MCO shall ensure service continuity via a non-virtual delivery method and confirm that the participant's service plan reflects the participant's choice change.

- o The managed care organization shall be responsible for ensuring that the provider is educating and informing the participant on the scope of the virtual delivery of the service prior to documenting the choice of the individual.
- o The physical location where virtual services are provided, as well as the activities rendered as part of the service are monitored through KDADS licensing as well as the MCO.

Training Requirement

- Where virtual delivery of a service is requested by the participant and authorized by the managed care organization, the provider shall train the participant to use the solution or application and device (where a new device is provided).
- Training for the participant and staff must demonstrate trainees understands how the virtual services will ensure the participant's health, welfare, and independence.
- Training must demonstrate that staff and participant have the competency after training to successfully utilize the technology.
- o The training should assist the participant in attaining the knowledge required to operate technologies that facilitate successful virtual delivery of the service.
- o Staff training on the technology that will be utilized for the person in service. must be person-specific, mode of technology utilized for the participant. Training for both participant and staff must be documented with a plan for continuing education on the technology for participant and staff.

Units and delivery for virtual delivery is found in Main 8 B.

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

Kansas Virtual Delivery (VD) of HCBS services is not available for Children's Residential.

VD of service in bedrooms and bathrooms must be approved by the agency's Human Rights Committee before implementation.

Residential Supports cannot be provided in the participant's family home, unless household members are also receiving IDD non-PCS waiver services.

Payments for Residential Supports are not made for room and board, the cost of facility maintenance, upkeep, and improvement, other than such costs for modifications or adaptations to the facility required to assure the health and safety of individuals or to meet the requirements of the applicable life safety code. Payments will not be made for routine care and supervision which would be expected to be provided by family members or for which payment is made by a source other than Medicaid. The method by which the costs of room and board are excluded from payment for residential supports is specified in Appendix I-5.

To avoid overlap of services, Adult and Child Residential Habilitation is limited to those services not covered through EPSDT, the Medicaid State Plan or other HCBS services and which cannot be procured from other formal or informal resources. Waiver funding shall be the funding source of last resort and requires prior authorization from the MCO via the participant's Person-Centered Service Plan.

Participants of Adult and Child Residential Supports cannot also receive Personal Care Services, Overnight Respite, or Enhanced Care Services (ECS).

Room, board, and transportation costs are excluded in the cost of any IDD services except overnight facility-based respite.

Residential Supports cannot be provided to anyone who is in a nursing facility, acute hospital setting, or an ICF-IID. Residential Supports for adults are provided for individuals 18 years of age or older and must occur in a setting where the person does not live with someone who meets the definition of family, unless that family member is receiving IDD waiver services or on the waitlist for IDD waiver services, and are provided by entities licensed by KDADS. This setting must be ADA compliant, as well as compliant with the HCBS Settings Final Rule.

Children's Residential Supports cannot be provided in a home where more than two participants funded with State or Medicaid money reside, unless an exception has been granted.

For the provider to bill the daily rate for residential supports, the participant must have received a residential support service on the date that the provider is billing for. Residential Support services cannot exceed the specific services authorized on the participant's Service Plan. However, a provider of Residential Supports may respond to a residential crisis as prescribed by the participant's backup plan. A crisis is defined as a situation in which the participant or participant's representative requests assistance due to him/herself feeling unsafe, medical emergencies, mental health emergencies, and/or law enforcement involvement.

Service Delivery Method *(check each that applies):*

- Participant-directed as specified in Appendix E**
- Provider managed**

Specify whether the service may be provided by *(check each that applies):*

- Legally Responsible Person**
- Relative**
- Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Residential Support Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Supports

Provider Category:

Agency

Provider Type:

Licensed Residential Support Provider

Provider Qualifications

License *(specify):*

Licensed by KDADS consistent with K.A.R. 30-63-01 through 30-63-32 for Adult Residential Supports, or the Kansas Department of Health and Environment, as a licensed foster care setting for Children's Residential Supports.

Certificate *(specify):*

Other Standard *(specify):*

All HCBS providers are required to pass background checks consistent with the KDADS' Background Check policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have been substantiated for a prohibited offense as listed in K.S.A. 39-2009 is not eligible for reimbursement of services under Medicaid funding.

All providers must be an affiliate of the CDDO in the area in which the services are provided. All providers must be KMAP enrolled providers.

*All staff must be trained Abuse, Neglect, and Exploitation and staff who administer medications to Participants must be trained in medication administration.

Consistent with the Developmental Disabilities Reform Act, Providers:

*Must submit policies and procedures for KDADS approval.

*Must contract with a KanCare MCO or be an approved out-of-network provider with a KanCare MCO.

Verification of Provider Qualifications

Entity Responsible for Verification:

Managed Care Organizations in accordance with the Provider Qualification policy M2017-171.

Frequency of Verification:

The MCOs, with oversight by KDADS, shall verify provider qualifications annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

Supported Employment (SE)

HCBS Taxonomy:

Category 1:

03 Supported Employment

Sub-Category 1:

03010 job development

Category 2:

03 Supported Employment

Sub-Category 2:

03021 ongoing supported employment, individual

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Supported Employment services are ongoing support services for IDD participants to allow them to engage in competitive work in an integrated setting.

Competitive work is defined as work for which an individual is paid in accordance with the Fair Labor Standards Act.

An integrated work setting is defined as a job site that is similar to that of the general work force. Such work is supported by an activity needed to sustain paid employment by persons with IDD.

The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.

Supported Employment will prioritize competitive integrated employment which can include work outside the home or work in a home environment.

Completion of Vocational Rehabilitation or a letter, from DCF, stating the participant is not eligible for Vocational Rehabilitation is required prior to authorization of Supported Employment. In the event the participant is on a waiting list for Vocational Rehabilitation services, Supported Employment activities may be authorized until the point in time when Vocational Rehabilitation Services begin. Supported Employment activities shall not be authorized until the individual has applied to the local Vocational Rehabilitation Services office.

The following supported employment activities by Supported Employment agency staff are designed to assist individuals in acquiring and maintaining employment:

1. Individualized assessment.
2. Individualized job development and placement services that create an appropriate job match for the individual and the employer.
3. Ongoing support services necessary to assure job retention as identified in the Person-Centered Support Plan and Person-Centered Service Plan.
4. Training in related skills essential to secure and retain employment.

Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act, which includes Vocational Rehabilitation (20 U.S.C., 1401 et seq.).

Transportation between the participant's residence and the employment site is included in the rate paid to providers of Supported Employment services.

Kansas Virtual Delivery of HCBS Services.

Virtual delivery of a service is an electronic method of service delivery. The purpose of virtual delivery of a service is to maintain or improve a participant's functional abilities, enhance interactions, support meaningful relationships, and meaningfully participate in their community. Virtual delivery of services may be a service option to provide independence in licensed group homes, therapies or agency-directed personal care services. The participant should have other opportunities for integration in the community via other services the participant receives.

Virtual Delivery of a service shall mean the provision of services through equipment with the capability for live real-time audio-visual connection that allows the staff member to both see and hear the participant. Text messaging and e-mailing do not constitute virtual services and, therefore, will not be considered provision of direct services under specified HCBS Services.

Direct service can be provided through the virtual delivery of the service when all of the following requirements are met:

- a. The virtual delivery of the service ensures the participant's rights of privacy, dignity and respect, and freedom from coercion and restraint.
- b. The virtual delivery of the service does not isolate the participant from the community or interacting with people without disabilities.
- c. The virtual delivery of the service has been agreed to by the participant and their team and outlined in the Person-Centered Plan;
 - i. Participants must have an informed choice between in person or the virtual delivery of the service;
 - ii. The virtual delivery of a service cannot be the only service delivery provision for a participant seeking the given service; and
 - iii. Participants must affirmatively choose virtual delivery of the service over in-person services.
- d. Virtual delivery of a service is not, and will not be, used for the provider's convenience. The virtual delivery of the service must be used to support a participant to reach identified outcomes in the participant's Person-Centered Plan;

- e. Virtual delivery of a service must be documented appropriately as any other service being delivered, including start and end times.
- f. The virtual delivery of a service must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations to protect the privacy and security of the participant's protected health information.
- g. Virtual delivery of a service, including using phones, cannot be used to assess a participant for a medical emergency. The provider must develop and maintain written policies, train direct support staff on those policies, and advise participants and their person-centered planning team regarding those policies that address:
- h. Identifying individuals to intervene (such as uncompensated caregivers present in the participant's home), and ensuring they are present during provision of virtual delivery of the service in case the participant experiences an emergency; and processes for requesting such intervention if the participant experiences an emergency during provision of virtual services, including contacting 911 if necessary.
- i. The virtual services meets all federal and State requirements, policies, guidance, and complies with 42 CFR 442.301 (c)(4)(vi)(A) through (D) related to privacy, control of schedule, activities, and access to visitors.
- j. Providers furnishing a HCBS waiver service via virtual delivery of service must include virtual delivery of a service in their provider Program Service Plan prior to implementing.
- k. The provider must develop, maintain, and enforce written policies, approved by the MCO, which address:
- i. Identifying whether the participant's needs, including health and safety, can be addressed safely via virtual delivery of the service.
 - ii. How the provider will ensure the participant's rights of privacy, dignity and respect, and freedom from coercion and restraint during virtual delivery of the service.
 - iii. How the provider will ensure the virtual delivery of the service meets applicable information security standards; and
 - iv. iv. How the provider will ensure the provision of virtual delivery of the service complies with applicable laws governing individuals' right to privacy.

Instances

Virtual Delivery of a service will only be authorized when a waiver participant requests the service to be delivered virtually and the technology or device appropriate to support the virtual delivery of the service is available.

Instructions and Limitations

- The program participant's person-centered service plan must indicate the use of the virtual delivery of the service.
- The managed care organization must document the frequency of the virtual delivery of the service.
- The provider must also document and track how the service is delivered. Documentation must be done in the same manner as if it was delivered in person.
- Virtual delivery of a service shall be provided in real-time, not via a recording.
- When virtual delivery of the service is provided, the provider shall only render the service on a one-on-one/individualized basis.
- The service provider shall be responsible for providing the device or technology required to support the virtual delivery of the service. The Waiver program will not fund any costs associated with the provider's virtual delivery of the service such as obtaining, installing, and implementing equipment, internet, software applications, and other related expenses. These costs, in the virtual delivery of the service are part of the provider's operating costs.

Technology and Devices

- Virtual delivery of a service may leverage the existing technologies or devices belonging to the waiver participant.
- HCBS waiver funding shall NOT be used to purchase technologies or devices or internet connectivity for the primary purpose of virtual delivery of a service.
- The provider shall be responsible for the maintenance, upkeep and assurance the device is in working order.

Community Integration and Participant's Choice

- Where virtual delivery of a service is requested by the participant and authorized by the managed care organization, the following requirements shall be met to ensure the delivery method does not lead to isolating or regimenting the participant from the greater community.
 - o The virtual delivery of the service shall be provided in the participant's preferred setting.
 - The participant's choice for virtual delivery of a service shall be documented and included in their service plan.
 - o The participant shall be able to rescind their choice of virtual delivery of a service at any time.

When this occurs, the MCO shall ensure service continuity via a non-virtual delivery method and confirm that the

participant’s service plan reflects the participant’s choice change.

- o The managed care organization shall be responsible for ensuring that the provider is educating and informing the participant on the scope of the virtual delivery of the service prior to documenting the choice of the individual.
- o The physical location where virtual services are provided, as well as the activities rendered as part of the service are monitored through KDADS licensing as well as the MCO.

Training Requirement

- Where virtual delivery of a service is requested by the participant and authorized by the managed care organization, the provider shall train the participant to use the solution or application and device (where a new device is provided).
- Training for the participant and staff must demonstrate trainees understands how the virtual services will ensure the participant’s health, welfare, and independence.
- Training must demonstrate that staff and participant have the competency after training to successfully utilize the technology.

- o The training should assist the participant in attaining the knowledge required to operate technologies that facilitate successful virtual delivery of the service.
- o Staff training on the technology that will be utilized for the person in service. must be person-specific, mode of technology utilized for the participant. Training for both participant and staff must be documented with a plan for continuing education on the technology for participant and staff.

Units and delivery for virtual delivery is found in Main 8 b

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

- a. FFP cannot be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: 1) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program, 2) Payments that are passed through to users of supported employment programs; or 3) Payments for training that is not directly related to an individual's supported employment program.
- b. Supported Employment must be provided in a place of business or a setting that has otherwise been approved by KDADS, and is compliant with the HCBS Settings Final Rule, and Employment First State and Federal policy.
- c. To avoid overlap of services, Supported Employment is limited to those services not covered through the Medicaid State Plan or other HCBS services and which cannot be procured from other formal or informal resources. Waiver funding shall be the funding source of last resort and requires prior authorization from the MCO via the participant's Person-Centered Service Plan.
- The IDD waiver funded Supported Employment activities must not be provided simultaneously with activities directly reimbursed by Kansas Vocational Rehabilitation Services.
- d. Supported Employment cannot be provided in a sheltered work setting.
- e. Supported Employment must be provided away from the participant’s place of residence, unless an in-home business exception has been granted or the Participant works competitively from their residence. Documentation of employment in the home will be provided to KDADS for verification of the Participant's choice to work competitively in their residence. This exception will be requested by the CDDO to the IDD Program Manager.
- f. Supported Employment cannot be provided to anyone who is an inpatient of a hospital, nursing facility or an ICF-IID.

Service Delivery Method *(check each that applies):*

- Participant-directed as specified in Appendix E**
- Provider managed**

Specify whether the service may be provided by *(check each that applies):*

- Legally Responsible Person**
- Relative**
- Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Supported Employment Provider

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Supported Employment (SE)

Provider Category:

Agency

Provider Type:

Licensed Supported Employment Provider

Provider Qualifications

License (*specify*):

Licensed by KDADS consistent with K.A.R. 30-63-01 through 30-63-32.

Certificate (*specify*):

Other Standard (*specify*):

All HCBS providers are required to pass background checks consistent with the KDADS' Background Check policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have been substantiated for a prohibited offense as listed in K.S.A. 39-2009 is not eligible for reimbursement of services under Medicaid funding.

Consistent with the Developmental Disabilities Reform Act, Providers:

*Must submit policies and procedures for KDADS approval.

*All staff must be trained Abuse, Neglect, and Exploitation and staff who administer medications to Participants must be trained in medication administration.

*Enrolled KMAP provider

*Contract with A MCO or be an approved out-of-network provider

All providers must be an affiliate of the CDDO in the area in which the participant accesses services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Managed Care Organizations in accordance with the Provider Qualification policy M2017-171.

Frequency of Verification:

The MCOs, with oversight by KDADS, shall verify provider qualifications annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Financial Management Services

Alternate Service Title (if any):

Financial Management Services (FMS)

HCBS Taxonomy:

Category 1:

12 Services Supporting Self-Direction

Sub-Category 1:

12010 financial management services in support of self-direction

Category 2:

12 Services Supporting Self-Direction

Sub-Category 2:

12020 information and assistance in support of self-direction

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Within the self-directed model and Kansas State law, K.S.A. 39-7, 100, participants have the right to make decisions about, direct the provisions of, and control the Personal Care Services received by such individuals including selecting, training, managing, paying and dismissing of a direct support worker. Financial Management Services (FMS) is provided through a third party and is designed to assist the waiver participant under the employer authority using the CMS approved Vendor Fiscal Agent model.

Services in support of participant direction are offered whenever a waiver affords participants the opportunity to direct some or all of their waiver services. The participant is the sole employer of the direct service worker. The FMS provider is responsible for the provision of Information and Assistance tasks to assist the participant with understanding his or her role and responsibilities as the employer and his or her responsibilities under self-direction. The FMS KMAP manual details the responsibilities of the FMS provider, waiver participant and the MCO.

MCO Responsibilities

The FMS KMAP manual and State policy detail the responsibilities of the MCO, in relation to FMS.

The MCO will ensure that individuals seeking or receiving self-directed services have been informed of the benefits and responsibilities of self-direction and provide the participant with a choice of FMS providers. The choice will be presented to the individual initially at the time self-direction is chosen, annually during the creation of his/her Person-Centered Service Plan, or at any time requested by the participant or the individual directing services on behalf of the participant. The MCO is responsible for documenting the provider chosen by the individual. In addition, the MCO is responsible for informing the participant of the process for changing or discontinuing an FMS provider and the process for ending self-direction. The MCO is responsible for informing the participant or the participant's legal guardian that the participant can change to agency-directed services at any time if the participant no longer desires to self-direct his/her service(s). This service does not duplicate other waiver services. Where the possibility of duplicate provision of services exists, the participant's Person-Centered Service Plan shall clearly delineate responsibilities for the performance of activities.

FMS Provider Responsibilities

FMS support is available for the participant (or the individual assigned by the participant, such as a representative, family member, parent, spouse, adult child, guardian) who has chosen to self-direct some or all services, to assist the participant by performing administrative and payroll functions. FMS is available to participants who reside in their own private residence or the private home of a family member and have chosen to self-direct their services. FMS assists the participant or participant's representative by providing two distinct types of tasks:

- (1) Administrative Tasks and
- (2) Information and Assistance (I & A) Tasks.

The FMS provider is also responsible for informing the participant that he/she must exercise responsibility for making the choice to self-direct his/her services, understand the impact of the choices made, and assume responsibility for the results of any decisions and choices that were made. The FMS provider is responsible for clearly communicating verbally and in writing the participants responsibilities relating his/her role as an employer of a direct service worker (DSW).

The FMS provider is responsible for certain administrative functions including:

1. Verification and processing of time worked and the provision of quality assurance;
2. Preparation and disbursement of qualified DSW payroll in compliance with federal, state and local tax; labor; and workers' compensation insurance requirements; making tax payments to appropriate tax authorities;
3. Performance of fiscal accounting and expenditure reporting to the participant or participant's representative and the state, as required.
4. Assistance to ensure the basic minimum qualifications set by the State are met in order to ensure participant safety, health and welfare.

The FMS provider is responsible for Information and Assistance functions including:

1. Explanation of all aspects of self-direction and subjects pertinent to the participant or participant's representative in managing and directing services;
2. Assistance to the participant or participant's representative in arranging for, directing and managing services;
3. Assistance in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services;
4. Offers practical skills training to enable participants or representatives to independently direct and manage waiver services such as recruiting and hiring DSWs, managing workers, and providing effective communication and problem-solving.

Participant Responsibilities

1. Act as the employer for the DSW or designate a representative to manage or help manage DSWs. See definition of representative above.
2. Negotiate a FMS Service Agreement with the chosen FMS provider that clearly identifies the roles and responsibilities of the participant and the FMS provider
3. Establish the wage of the DSW(s)
4. Select DSW(s)
5. Refer the DSW to the FMS provider for completion of required human resources and payroll documentation. In cooperation with the FMS provider, all employment verification and payroll forms must be completed.
6. Negotiate an Employment Service Agreement with the DSW that clearly identifies the responsibilities of all parties, including work schedule.
7. Provide or arrange for appropriate orientation and training of DSW(s).
8. Determine schedules of DSW(s).
8. Determine tasks to be performed by DSW(s) and where and when they are to be performed in accordance with the services approved within the Person-Centered Service Plan.
9. Manage and supervise the day-to-day HCBS activities of DSW(s).
10. Verify time worked by DSW(s) was delivered according to the Person-Centered Service Plan; and approve and validate time worked electronically or by exception paper timesheets.
11. Assure utilization of EVV system to record DSW time worked and all other required documents to the FMS provider for processing and payment in accordance with established FMS, State, and Federal requirements. The EVV/timesheet will be reflective of actual hours worked in accordance with an approved Person-Centered Service Plan.
12. Report work-related injuries incurred by the DSW(s) to the FMS provider.
13. Develop an emergency worker back-up plan in case a substitute DSW is ever needed on short notice or as a short-term replacement worker.
14. Assure all appropriate service documentation is recorded as required by the State of Kansas HCBS Waiver program policies, procedures, or by Medicaid Provider Agreement.
15. Inform the FMS provider of any changes in the status of DSW(s), such as changes of address or telephone number, in a timely fashion.
16. Inform the FMS provider of the dismissal of a DSW within 3 working days.
17. Inform the FMS provider of any changes in the status of the participant or participant's representative, such as the participant's address, telephone number or hospitalizations within 3 working days.
18. Participate in required quality assurance visits with MCOs, and State Quality Assurance Staff, or other Federal and State authorized reviewers/auditors.

Payment for FMS

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

FMS Provider must be an affiliate of the CDDO in the area in which the service will be provided.

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

Access to this service is limited to participants who chose to participant-direct some or all of the service(s) when participant-direction is offered.

FMS service is reimbursed per member per month. FMS service may be accessed by the participant at a minimum monthly or as needed in order to meet the needs of the participant.

A participant may have only one FMS provider per month.

All employers must act in accordance with the Fair Labor Standards Act. Additional payment cannot be supplemented by the participant or natural supports.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Financial Management Services Provider

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction

Service Name: Financial Management Services (FMS)

Provider Category:

Agency

Provider Type:

Financial Management Services Provider

Provider Qualifications

License (*specify*):

Not applicable

Certificate (*specify*):

Not applicable

Other Standard (*specify*):

Enrolled FMS providers will furnish FMS according to Kansas model.

Organizations interested in providing FMS are required to contract with KDADS, or their designee. The contract must be signed prior to enrollment in KMAP to provide the service. The agreement identifies the waiver programs under which the organization is requesting to provide FMS and outlines general expectations and specific provider requirements. The agreement will be renewed annually, and approval is subject to satisfactory completion of the required GAAP audit. KanCare MCOs will not credential any application without a fully executed FMS Provider agreement.

All HCBS providers are required to pass background checks consistent with the KDADS' Background Check Policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have a prohibited offense, as listed in K.S.A. 39-2009, is not eligible for reimbursement of services under Medicaid funding.

For new organizations seeking to be a FMS provider, the FMS provider agreement and accompanying documentation are reviewed by KDADS and/or their designee to ensure that all assurances are satisfied as part of a readiness review prior to signing by the Secretary of KDADS, or designee.

FMS organizations are required to submit the following documents with the signed FMS provider agreement as a part of the readiness review:

- Community Developmental Disability Organization (CDDO) affiliate agreement
- Secretary of State Certificate of Corporate Good Standing
- W-9 form
- Proof of Liability Insurance
- Proof of Workers Compensation insurance
- Copy of the most recent quarterly operations report or estimate for first quarter operations
- Financial statements (last 3 months bank statements or documentation of line of credit)
- Copy of the organization's Policies and Procedures manual, to include information that covers requirements listed in the FMS Medicaid Provider Manual.
- Including process for conducting background checks
- Process for establishing and tracking workers wage with the participant

Prospective providers are not permitted to provide services to a participant until verification of background clearance is available for review by the participant in accordance with the list of prohibited offenses.

Verification of Provider Qualifications
Entity Responsible for Verification:

Managed Care Organizations in accordance with the Provider Qualification policy M2017-171.

Frequency of Verification:

The MCOs, with oversight by KDADS, shall verify provider qualifications annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not

specified in statute.

Service Title:

Children's Integrated Community Supports (CHICS)

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04020 day habilitation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Children's Integrated Community Supports (CHICS)

Children's Integrated Community Supports is designed to provide group-based supports and supervision for school-aged Participants with intellectual and developmental disabilities (IDD). Children from 5 years old to school-leaving age with intellectual and developmental disabilities often require specialized care and socialization. This service offers a support system for families where standard childcare options are not sufficient to their children's unique developmental needs, while also allowing an opportunity for integrated care with non-disabled child peers. Traditional childcare providers do not have the supports needed to care for children with IDD. Direct support professionals (DSPs) provide and offer a wide variety of supports/activities that are not accessible in the child's home or in a childcare setting. Children's Integrated Community Supports offers the care provided from a direct support professional but with the addition of peer-to-peer interaction and socialization. DSPs are available to assist with ADLs and behavioral supports throughout the day. Because of different individual levels of care, 1:1 staffing is not always needed. Staffing is determined according to the specific, assessed needs of each child. The supports that are provided are necessary to ensure the health, safety, and wellness of all persons involved. CHICS creates an environment that mimics the experience a typically developing child would receive if they did not require extraordinary care. The scope, duration, and amount of services authorized by the MCO shall be consistent with the Participant's assessed need as documented in the Person-Centered Service Plan. This service can be provided in a variety of settings in the community. Services must be provided outside of the Participant's residence.

Children's Integrated Community Supports includes supports for the participant in the following areas:

Activities of Daily Living (ADLs) in accordance with K.A.R. 30-5-300.

Instrumental Activities of Daily Living (IADLs) in accordance with K.S.A 65-5115, K.A.R. 28-51-113, and K.A.R. 30-5-300.

Supervision to provide for the health, safety, and welfare of the participant.

Assistance and accompaniment for exercise, socialization, and recreational activities.

Assistance accessing medical care.

Children's Integrated Community Supports serves Participants when it is determined and documented within the PCSP to meet the child's needs and that the needs of each individual in the group can be safely met.

The intention of this service is to provide specialized care and socialization for children with intellectual and developmental disabilities, addressing needs beyond the range of activities that a typical, licensed childcare center would perform. This extraordinary care is necessary to assure the health and welfare of the individual.

Payments for CHICS cover ADLs, IADLs, and other disability-related supports as documented in the PCSP. Parents or legal guardians are responsible for the general cost of standard childcare, while waiver funds for this service are specifically allocated for the additional, extraordinary care required due to the child's disability.

This service provides the opportunity for Participants to receive a supporting service without the necessity of 1:1 caregiver to participant ratio.

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

Children's Integrated Community Supports is limited to 16 units per day on school days and 32 units per day on non-school days. Exceptions may be granted by the MCO based on the child's disability needs or unique family circumstances and clearly documented in the child's PCSP.

This service is exclusively delivered in a group setting. Each child is part of a group with up to two other Participants and may include other children without disabilities. Reimbursement, however, is limited to participants of the HCBS-IDD waiver. Non-emergency Medical Transportation (NEMT) is a State Plan service and can be accessed through the MCO.

The service must occur in an integrated community location, including anywhere the Participant socializes. CHICS cannot be provided in a school setting and cannot be used for education, as a substitute for educationally related services, or for transition services as outlined in the participant's Individualized Education Program (IEP).

Services cannot be furnished to an individual who is an inpatient or resident of a hospital, nursing facility, intermediate care facility for persons with Intellectual Disability (ICF-IID), or institution for mental disease.

A CHICS worker may not perform any duties not delegated by the Participant or Participant's representative with the authority to direct services or perform duties as approved by the Participant's physician. The CHICS worker's task(s) must be identified as an authorized task or tasks in the Participant's authorized Person-Centered Service Plan.

The services under the IDD waiver are limited to services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. Waiver funding shall be the funding source of last resort and requires prior authorization from the MCO via the participant's Person-Centered Service Plan. Service plans for which it is determined that the provisions of CHICS would be a duplication of services will not be approved. CHICS worker cannot perform any duties for the Participant that would otherwise be consistent with the Supported Employment definition. CHICS shall not be authorized for the times a Participant has Residential or Day supports authorized in the Participant's Person-Centered Service Plan.

Prevocational, educational services, or supported employment services available to the participant through a local educational agency under the Individuals with Disabilities Act (IDEA) or the Rehabilitation Act of 1973 are not covered.

All HCBS providers are required to pass background checks consistent with the KDADS' Background Check Policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have been substantiated for a prohibited offense as listed in K.S.A. 39-2009 is not eligible for reimbursement of services under Medicaid funding.

Service Delivery Method *(check each that applies):*

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies):*

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Children's Integrated Community Supports (CHICS)

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License (specify):

Home Health Agency License
 Employees of a Home Health Agency as specified in KSA 65-5101 thru KSA 65-5117.

Certificate (specify):

Other Standard (specify):

All HCBS providers are required to pass background checks consistent with the KDADS' Background Check policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have been substantiated for a prohibited offense as listed in K.S.A. 39-2009 is not eligible for reimbursement of services under Medicaid funding.
 Consistent with the DDRA, Providers:
 *Must submit policies and procedures for KDADS approval.
 *All staff must be trained Abuse, Neglect, and Exploitation and staff who administer medications to Participants must be trained in medication administration.
 Providers must be enrolled in KMAP; and must either contract with a KanCare MCO or be an approved out-of-network provider with a KanCare MCO.
 Providers must be affiliated with the CDDO for each area in which the services will be provided.
 Managed Care Organizations in accordance with the Provider Qualification Policy.

Verification of Provider Qualifications

Entity Responsible for Verification:

MCOs in accordance with the Provider Qualification Policy.

Frequency of Verification:

The MCOs, with oversight by KDADS, shall verify provider qualifications annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Enhanced Care Service

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08030 personal care

Category 2:

09 Caregiver Support

Sub-Category 2:

09012 respite, in-home

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Enhanced Care Services (ECS) provide supervision and/or non-nursing physical assistance during a participant’s normal sleeping hours in his/her place of residence. Enhanced Care Services (ECS) is available to participants who demonstrate an assessed need for a minimum of 6 hours of additional care for overnight support, during the participant's normal hours of sleep, and the assessed need cannot be met by the use of Personal Emergency Response Services (PERS), informal supports or other less restrictive services. The ECS worker must be immediately available to provide supervision or physical assistance with tasks such as toileting, transferring, mobility, and medication reminder as needed. The ECS provider must be ready and able to contact a doctor, hospital, or medical professional in the event of an emergency. ECS must be provided in the participant’s home. Services providers must remain in the participant’s home for the duration of this service provision in accordance with the participant’s authorized Person-Centered Service Plan.

ECS can be provided as a self-directed or agency-directed service. If ECS is self-directed, the participant or designated representative is responsible for hiring, supervising, and terminating the employment of direct support workers; understanding the impact of those decisions; and assuming responsibility for the results of those decisions. For participants who are children, this service is not to be duplicative of services available via EPSDT.

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

Enhanced Care Services must be provided in accordance with the Enhanced Care Services policy.

A statement of medical necessity, signed by a physician, must be on record with the MCO in order to authorize ECS on a participant's Person-Centered Service plan.

Only one unit (a minimum of 6 hours) is allowed within a 24-hour period. 1 unit of service is equal to 6-12 hours within a 24-hour period.

ECS, in combination with other HCBS services, cannot exceed 24 hours within a 24-hour period.

If additional support is required, exceptions to Personal Care Service may be used to assure needed coverage up to 24 hours.

To avoid overlap of services, ECS is limited to those services not covered through the Medicaid State Plan or other HCBS services and which cannot be procured from other formal or informal resources. Waiver funding shall be the funding source of last resort and requires prior authorization from the MCO via the participant's Person-Centered Service Plan.

1. Participants whose Person-Centered Service Plan authorizes Residential Supports cannot receive ECS.
2. ECS may not be provided when a participant's Person-Centered Service Plan authorizes PCS as an alternative to Overnight Respite.
3. The participant's Person-Centered Service Plan must document that the Participant has an assessed need beyond what can be provided through Personal Emergency Response System (PERS).
4. ECS authorized for children in DCF custody cannot be provided by the waiver participant's foster parent as a waiver-funded service.

Overnight Respite Care and ECS may not be authorized on the same dates of service.

Participants residing in an institution, assisted living facility, residential setting or other type of group home are not eligible for ECS.

Participants in DCF custody cannot self-direct ECS.

Court appointed guardians and conservators shall not be paid to provide waiver services unless all potential conflicts of interest have been mitigated as per K.S.A. 59-3068.

- a. The court appointed guardian is responsible to report any potential conflicts to the court in the annual or special report per guardianship law and to maintain documentation of the court determination.
- b. In order to be paid to provide ECS to the participant, the court appointed guardian shall provide the special or annual report copy disclosing the conflict of interest and the judge's approval order of said report, plus determination of no guardian conflict of interest to the MCO and FMS provider.
- c. If the court determines that all potential conflict of interest concerns are not mitigated, the legal guardian can:
 - d. Pick someone else to provide the HCBS services to the participant. The participant's MCO or FMS provider may assist the legal guardian to find a support worker, or to seek other HCBS service providers in the community; OR
 - e. Appoint someone as a Designated Representative to develop and direct the participant's HCBS Person Centered Service Plan.
 - f. An activated durable power of attorney is not permitted to be a paid provider for participant unless a Designated Representative is appointed to direct the individual's care and workers.
 - g. An exception to the criteria may be granted by the MCO when a participant/guardian lives in a rural setting and the nearest agency-directed service provider available to provide services is in excess of 50 miles from the participant residence or the location is so remote that HCBS Program Services would otherwise not be available. For waiver purposes, relatives are defined as parents of minors, and spouses of waiver participants. ECS may be used to pay parents or participant's spouse. Parents of minors and spouses must meet the provider qualifications for ECS.

Enhanced Care Services are limited to those services not covered through the Medicaid State Plan or other HCBS services and which cannot be procured from other formal or informal resources. Waiver funding shall be the funding source of last resort and requires prior authorization from the MCO via the participant's Person-Centered Service Plan. The services under the KS HCBS IDD Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual ECS provider
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Enhanced Care Service

Provider Category:

Individual

Provider Type:

Individual ECS provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

1. Be at least eighteen years of age; or
2. Must have a High School Diploma or equivalent;
3. Have the necessary training or skills in order to meet the needs of the participant
4. Must sign an agreement with the KMAP-enrolled Financial Management Services (FMS) provider, acting as an administrative agent on behalf of the participant. FMS provider must be contracted and credentialed with participant's MCO.

All HCBS providers are required to pass background checks consistent with the KDADS' Background Check Policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have been substantiated for a prohibited offense as listed in K.S.A. 39-2009 is not eligible for reimbursement of services under Medicaid funding.

Verification of Provider Qualifications

Entity Responsible for Verification:

Managed Care Organizations in accordance with the Provider Qualification policy M2017-171.

Frequency of Verification:

The MCOs, with oversight by KDADS, shall verify provider qualifications annually.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Enhanced Care Service

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License (specify):

Home Health Agency License

Employees of a Home Health Agency as specified in K.A.S. 65-5101 through K.S.A. 65-5117.

Certificate (specify):

Other Standard (specify):

Must be employed by and under the direct supervision of a home health agency licensed by the Kansas Department of Health and Environment, enrolled as a KMAP provider and contracted with a KanCare MCO (In accordance with K.S.A 65-5115 and K.A.R. 28-51-113).

Provider must be affiliated with the participant's CDDO.

1. Be at least eighteen years of age; or
2. Must have a High School Diploma or equivalent;
3. Complete KDADS' Approved Skill Training requirements, if applicable
4. Have the necessary training or skills in order to care for the participant, as requested either by the participant or participant's legal representative, qualified medical provider, or KanCare MCO. KMAP-enrolled provider contracted and credentialed with KanCare MCO.

All HCBS providers are required to pass background checks consistent with the KDADS' Background Check Policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have been substantiated for a prohibited offense as listed in KSA 39-2009 is not eligible for reimbursement of services under Medicaid funding.

Verification of Provider Qualifications

Entity Responsible for Verification:

Managed Care Organizations in accordance with the Provider Qualification policy M2017-171.

Frequency of Verification:

The MCOs, with oversight by KDADS, shall verify provider qualifications annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home and Environmental Modification Services (HEMS)

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14020 home and/or vehicle accessibility adaptations

Category 2:

17 Other Services

Sub-Category 2:

17030 housing consultation

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Home and Environmental Modification Services (HEMS) are physical modifications to the participant's home based on an assessment designed to support the participant's efforts to function with greater independence and to create a safer, healthier environment. The need for HEMS adaptations shall be determined through the person-centered service plan. Participants will have complete access to choose any qualified provider with consideration given to the most economical option available to meet the participant's assessed needs.

This service is limited to those services not covered through the Medicaid State Plan or Early and Periodic Screening, Diagnostic and Treatment (EPSDT). HCBS waiver funding requires prior authorization from the participant's chosen KanCare MCO.

Instance

HEMS adaptations may include but shall not be limited to the following:

- Modifications to the environment
 - o Installation of grab bars;
 - o Construction of access ramps and railings;
 - o Installation of detectable warnings on walking surfaces;
 - o Alerting devices for participant who has a hearing or sight impairment;
 - o Adaptations to the electrical, telephone, and lighting systems;
 - o Generator to support medical and health devices that require electricity;
 - o Widening of doorways and halls;
 - o Door openers;
 - o Installation of lifts and stair glides (with the exception of elevators), such as overhead lift systems and vertical lifts;
 - o Bathroom modifications for accessibility and independence with self-care;
 - o Kitchen modifications for accessibility and independence;
 - o Alarms or locks on windows, doors, and fences; protective padding on walls, floors, or pipes; Plexiglas, safety glass, a protected glass coating on windows; outside gates and fences; brackets for appliances; raised/lowered electrical switches and sockets; and safety screen doors which are necessary for the health, welfare, and safety of the participant;
 - o Any home modifications not listed here but determined to be of remedial benefit to the participant by a qualified healthcare provider.
- Training on use of HEMS;
- Service and maintenance of the modification.

To determine an economical viable option available to meet a participant's assessed needs, the Managed Care Organization (MCO) shall evaluate the most cost-effective HEMS solution by completing a process that includes, but is not limited to the following:

- Prior to authorizing HEMS, the MCO shall coordinate with other benefits the participant may have.
 - o Waiver funding shall be the funding source of last resort and requires prior authorization from the MCO via the participant's Person-Centered Service Plan.
- The MCO shall request an in-home or remote assessment, as appropriate, of the participant's needs and recommendations from a therapist or a person qualified to complete home usability/accessibility assessments.
 - o This helps determine the options available for meeting the participant's need; and which option may be the most cost-effective.
 - The MCO will request bids for home and environmental modification services.
 - The MCOs will review both the participant's assessed needs and the received bids to ensure that items, materials, or services are within the scope of what is needed and covered and are not of extraordinary cost.
 - Certain conditions besides cost will determine if a bid is to be accepted.
 - o The MCO will not accept bids solely based on the cost proposed
 - o Bids that do not meet the participant's needs or submitted by contractors with a low work quality history will not be considered.
- A participant that is a Tribe member may opt to be served through a federally recognized Tribal entity that does not wish to contract with the MCO or FMS provider. In the case, the state shall provide a separate provider agreement which will allow the tribal vendor to receive direct payment from Medicaid.

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

Instructions and Limitations

- Upon delivery to the participant (including installation), the HEMS adaptation must be in good operating condition and repair in accordance with applicable specifications.

HEMS adaptations do not include:

- Improvements to the residence that:
 - o Are of general utility;
 - o Are not of direct medical or remedial benefit to the participant or otherwise meets the needs of the participant as defined in instances above;
 - o Add to the home’s total square footage, unless the construction is necessary, reasonable, and directly related to the participant’s access to the participant’s primary residence; or
 - o Are required by local, county, or State law when purchasing or licensing a residence;
- A generator for use other than to support the participant’s medical and health devices that require electricity for safe operation; or
- Traditional shafted elevator. An elevator or escalator.

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Contractor (Direct Contractor)
Agency	Center for Independent Living
Individual	Non-KanCare Enrolled/Indirect Contractor

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home and Environmental Modification Services (HEMS)

Provider Category:

Individual

Provider Type:

Individual Contractor (Direct Contractor)

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

- a. Enrolled in KanCare
- b. Appropriately Licensed in Service
- c. Certificate of Worker's Compensation and General Liability Insurance
- d. Proof of business establishment for a minimum of two (2) consecutive years
- e. Passing Background Checks consistent with the KDADS' Background Check policy
- f. Compliance with all regulations related to Abuse, Neglect, and Exploitation.

Verification of Provider Qualifications

Entity Responsible for Verification:

Managed Care Organization, KMAP enrollment system, KDADS' background checks.

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home and Environmental Modification Services (HEMS)

Provider Category:

Agency

Provider Type:

Center for Independent Living

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

- a. Enrolled in KanCare
- b. Certificate of Worker's Compensation and General Liability Insurance
- c. Passing Background Checks consistent with the KDADS' Background Check policy
- d. Compliance with all regulations related to Abuse, Neglect, and Exploitation

Verification of Provider Qualifications

Entity Responsible for Verification:

Managed Care Organization, KMAP enrollment system, KDADS' background checks

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home and Environmental Modification Services (HEMS)

Provider Category:

Individual

Provider Type:

Non-KanCare Enrolled/Indirect Contractor

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

- a. Affiliation with a Center for Independent Living
- b. Certificate of Worker's Compensation and General Liability Insurance
- c. Proof of business establishment for a minimum of two (2) consecutive years
- d. Passing Background Checks consistent with the KDADS' Background Check policy
- e. Compliance with all regulations related to Abuse, Neglect, and Exploitation

Verification of Provider Qualifications

Entity Responsible for Verification:

Managed Care Organization, Center for Independent Living

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Medical Alert Rental

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14010 personal emergency response system (PERS)

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

The purpose of this service is to provide support to a consumer who has a medical need that could become critical at any time. The medical alert device is a small instrument carried or worn by a Participant which, by the push of a button, automatically dials the telephone of a predetermined responder who will answer the call for help 24 hours a day, 7 days a week.

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

To avoid overlap of services, Medical Alert Rental is limited to those services not covered through the Medicaid State Plan or other HCBS services and which cannot be procured from other formal or informal resources. Waiver funding shall be the funding source of last resort and requires prior authorization from the MCO via the participant's Person-Centered Service Plan.

Rental, not the purchase, of this equipment is covered. Maintenance of equipment is included as a part of the rental agreement.

Personal Emergency Response System services must be billed at a monthly rate.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Hospital
Agency	Emergency Transportation Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Medical Alert Rental

Provider Category:

Provider Type:

Provider Qualifications**License (specify):**

Certificate (specify):

Other Standard (specify):

Providers must also be a KanCare enrolled provider; and must either contract with a KanCare MCO or be an approved out-of-network provider with a KanCare MCO. Services and equipment must conform to industry standards and any federal, state, and local laws and regulations that govern this service. The emergency response center must be staffed on a 24 hour/7 days a week basis by trained personnel.

All HCBS providers are required to pass background checks consistent with the KDADS' Background Check Policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have a prohibited offense, as listed in K.S.A. 39-2009, is not eligible for reimbursement of services under Medicaid funding.

Provider must be an affiliate of the CDDO in the area in which the service is provided.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Frequency of Verification:

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service
Service Name: Medical Alert Rental

Provider Category:

Provider Type:

Provider Qualifications**License (specify):**

Certificate (specify):

N/A

Other Standard (specify):

Providers must also be a Medicaid or KanCare enrolled provider; and must contract with a KanCare MCO or be an approved out-of-network provider with a KanCare MCO.

All HCBS providers are required to pass background checks consistent with the KDADS' Background Check Policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have a prohibited offense, as listed in K.S.A. 39-2009, is not eligible for reimbursement of services under Medicaid funding.

Services and equipment must conform to industry standards and any federal, state, and local laws and regulations that govern this service. The emergency response center must be staffed on a 24 hour/7 days a week basis by trained personnel.

Must be an affiliate of the CDDO for the area in which the service is provided.

Verification of Provider Qualifications

Entity Responsible for Verification:

Managed Care Organizations in accordance with the Provider Qualification policy M2017-171.

Frequency of Verification:

The MCOs, with oversight by KDADS, shall verify provider qualifications annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Specialized Medical Care

HCBS Taxonomy:

Category 1:

05 Nursing

Sub-Category 1:

05010 private duty nursing

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

This service provides long-term nursing support for medically-fragile and technology-dependent participants. The required level of care must provide medical support for participants needing ongoing, daily care that would otherwise require the participant to be in a hospital. The intensive medical needs of the participant must be met to ensure that the participant can live outside of a hospital or Intermediate Care Facility for Individuals with an Intellectual Disability (ICF-IID).

For the purpose of this waiver, a provider of Specialized Medical Care (SMC) must be an RN or an LPN under the supervision of an RN. Providers of this service must be trained with the medical skills necessary to care for and meet the medical needs of participants within the scope of the State’s Nurse Practice Act. The service may be provided in all customary and usual community locations including where the participant resides and socializes. The provider agency will ensure that qualified nurses are employed and able to meet the specific medical needs of the participant.

Providers of this service will be reimbursed for medically appropriate and necessary services relative to the level of need as identified in the participant’s Service Plan.

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

Access to Specialized Medical Care Services is limited to those recipients who's needs can only be met by an RN or LPN as determined by a needs assessment based on how often and to what extent a person needs can only be met through the use of medical technology.

This waiver service is only provided to individuals age 21 and over. All medically necessary Specialized Medical Care services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. Specialized Medical Care is limited to those services which cannot be procured from other formal or informal resources. Waiver funding shall be the funding source of last resort and requires prior authorization from the MCO via the participant's Person-Centered Service Plan.

1. Specialized Medical Care Services recipients may not also receive Residential Supports or Personal Care Services as an alternative to Specialized Medical Care Services.
2. Individuals who are eligible to receive EPSDT services may access Specialized Medical Services through the Medicaid state plan. Waiver limits do not apply to individuals receiving benefits under EPSDT.
3. Specialized Medical Care services authorized for children in DCF custody cannot be provided by the waiver participant's foster parent as a waiver-funded service.
4. Room, board and transportation costs are excluded.
5. Specialized Medical Care services may not be provided by a participant’s spouse or by a parent of a participant who is a minor child under 18 years of age.
6. A participant can receive Specialized Medical Care services from more than one worker, but no more than one worker can be paid for services at any given time of day. A Specialized Medical Care provider cannot be paid to provide services to more than one participant at any given time of day.

One unit is equal to 15 minutes.

Services furnished to a participant who is an inpatient or resident of a hospital, nursing facility, ICF-IID, or IMD are not reimbursable.

Per the KanCare contracts the MCOs are responsible for ensuring the individual’s needs are met with a combination of waiver, State Plan and community resources. The MCO would ensure via the Person-Centered Service Plan and monitoring of the plan that the needs of the participant are being met.

Service Delivery Method (*check each that applies*):

- Participant-directed as specified in Appendix E**
- Provider managed**

Specify whether the service may be provided by (*check each that applies*):

- Legally Responsible Person**
- Relative**
- Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Care

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License (*specify*):

1. A licensed LPN or RN by the Kansas State Board of Nursing.
2. Employees of a Home Health Agency as specified in K.S.A. 65-5101 through K.S.A. 65-5117.

Certificate (*specify*):

Other Standard (*specify*):

All providers of Specialized Medical Care must be in compliance with K.A.R. 30-63-21 through K.A.R. 30-63-30.

All HCBS providers are required to pass background checks consistent with the KDADS' Background Check Policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have a prohibited offense, as listed in K.S.A. 39-2009, is not eligible for reimbursement of services under Medicaid funding.

Providers must be an affiliate of the CDDO in the area in which the services are provided.

Providers must also be a KanCare enrolled provider; and must either contract with a KanCare MCO or be an approved out-of-network provider with a KanCare MCO.

Verification of Provider Qualifications

Entity Responsible for Verification:

Managed Care Organizations in accordance with the Provider Qualification policy M2017-171.

Frequency of Verification:

The MCOs, with oversight by KDADS, shall verify provider qualifications annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Specialized Medical Equipment and Supplies (SMES)

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

17010 goods and services

Category 2:

14 Equipment, Technology, and Modifications

Sub-Category 2:

14032 supplies

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Specialized medical equipment and supplies include: (a) devices, controls, software, or appliances, specified in the person-centered service plan, that enable participants to increase their ability to perform activities of daily living; (b) devices, controls, software, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment not available under the State plan that is necessary to address participant needs.

The services under the KS HCBS IDD Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

- The program participant’s person-centered planning team shall assess them for their need for Specialized Medical Equipment and Supplies (SMES). This service supports the achievement of the outcomes as specified in the program participant's Person-Centered Service Plan.
- The managed care organization will access the State plan to cover medical supplies and equipment that the state of Kansas has made available under the State plan, under Durable Medical Equipment
- To avoid overlap of services, this service is limited to those services not covered through the Medicaid State Plan, Early and Periodic Screening, Diagnostic and Treatment (EPSDT), or other HCBS services and which cannot be procured from other formal or informal resources. Waiver funding shall be the funding source of last resort and requires prior authorization from the MCO via the participant's Person-Centered Service Plan.
- The coverage/provision of SMES furnished through this service shall include the costs of maintenance and upkeep of devices, and training on the utilization of the devices. This includes normal wear and tear. Intentional destruction or damage to device will not be a covered cost.
- HCBS funding shall be the funding source of last resort and requires prior authorization from the MCO via the participant's Person-Centered Service Plan.
- A participant that is a Tribe member may opt to be served through a federally recognized Tribal entity that does not wish to contract with the MCO or FMS provider. In this case, the state shall provide a separate provider agreement which will allow the tribal vendor to receive direct payment from Medicaid.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Center for Independent Living
Individual	Individual Contractor (Direct Contractor)
Individual	Non-KanCare Enrolled/Indirect Contractor

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Specialized Medical Equipment and Supplies (SMES)

Provider Category:

Agency

Provider Type:

Center for Independent Living

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (*specify*):

- a. Enrolled in KanCare
- b. Certificate of Worker's Compensation and General Liability Insurance
- c. Passing Background Checks consistent with the KDADS' Background Check policy
- d. Compliance with all regulations related to Abuse, Neglect, and Exploitation

Verification of Provider Qualifications

Entity Responsible for Verification:

Managed Care Organization, KMAP enrollment system, KDADS' background checks

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Specialized Medical Equipment and Supplies (SMES)

Provider Category:

Individual

Provider Type:

Individual Contractor (Direct Contractor)

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

- a. Enrolled in KanCare
- b. Appropriately Licensed in Service
- c. Certificate of Worker's Compensation and General Liability Insurance
- d. Proof of business establishment for a minimum of two (2) consecutive years
- e. Passing Background Checks consistent with the KDADS' Background Check policy
- f. Compliance with all regulations related to Abuse, Neglect, and Exploitation

Verification of Provider Qualifications

Entity Responsible for Verification:

Managed Care Organization, KMAP enrollment system, KDADS' background checks

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Specialized Medical Equipment and Supplies (SMES)

Provider Category:

Individual

Provider Type:

Non-KanCare Enrolled/Indirect Contractor

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

This entity will subcontract with a Center for Independent Living, CILs perform the background checks.

- a. Affiliation with a Center for Independent Living
- b. Certificate of Worker's Compensation and General Liability Insurance
- c. Proof of business establishment for a minimum of two (2) consecutive years
- d. Passing Background Checks consistent with the KDADS' Background Check policy
- e. Compliance with all regulations related to Abuse, Neglect, and Exploitation

Verification of Provider Qualifications

Entity Responsible for Verification:

Managed Care Organization, Center for Independent Living.

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Vehicle Modification Services (VMS)

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

17990 other

Category 2:

14 Equipment, Technology, and Modifications

Sub-Category 2:

14020 home and/or vehicle accessibility adaptations

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

In HCBS waivers operated in the Kansas, Vehicle Modification Services (VMS) are adaptations or alterations to a vehicle that is the participant's primary means of transportation. Vehicle modifications are specified by the person-centered service plan and are designed to accommodate the needs of the participant and enable the participant to integrate more fully into the community and to ensure the health, welfare and safety and integration by removing barriers to transportation.

Reimbursement for this service is limited to the participant's assessed needs and based on the person-centered service plan. Participants will have the choice to choose any qualified provider with consideration given to the most economical option available to meet the participant's assessed needs.

This service is limited to those services not covered through the Medicaid State Plan, Early and Periodic Screening, Diagnostic and Treatment (EPSDT). HCBS waiver funding is used as the last resort's funding source and requires prior authorization from the participant's chosen KanCare MCO.

To determine an economical viable option available to meet a participant's assessed needs, the Managed Care Organization (MCO) shall evaluate the most cost-effective VMS solution by completing a process that includes, but is not limited to the following:

- Prior to authorizing VMS, the MCO shall coordinate with other benefits the participant may have.
 - o The MCO shall make attempts to identify potential community resources or natural supports.
 - o Waiver funding requires prior authorization from the MCO via the participant's Person-Centered Service Plan.
- The MCO shall request an in-home or remote assessment, as appropriate, of the participant's needs and recommendations from a therapist or a person qualified to complete home usability/accessibility assessments.
 - o This helps determine the options available for meeting the participant's need; and which option may be the most cost-effective.
- The MCO will request bids for vehicle modification services.
 - o This process will not be completed where the MCO cannot find more than one provider/contractor to provide a bid.
- The MCOs will review both the participant's assessed needs and the received bids to ensure that items, materials, or services are within the scope of what is needed and covered and are not of extraordinary cost.
- Certain conditions besides cost will determine if a bid is to be accepted.
 - o The MCO will not accept bids solely based on the cost proposed.
 - o Bids that do not meet the participant's needs or submitted by contractors with a low work quality history will not be considered.
 - o The following are specifically excluded: 1. Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual; 2. Purchase or lease of a vehicle; and 3. Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications
- A participant that is a Tribe member may opt to be served through a federally recognized Tribal entity that does not wish to contract with the MCO or FMS provider. In the case, the state shall provide a separate provider agreement which will allow the tribal vendor to receive direct payment from Medicaid.

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

IDD Waiver participants do not have a cap on this service.

- Upon delivery to the participant (including installation), the Vehicle Modification must be in good operating condition and repair in accordance with applicable specifications.
- o The State cannot provide assistance with modifications on vehicles that are not registered under the participant or legally responsible parent of a minor or other primary caretaker.

Vehicle Modification Services (VMS) shall include:

- Assessment services to
 - o help determine specific needs of the participant as a driver or passenger,
 - o review modification options, and
 - o development of a prescription for required modifications of a vehicle;
- Assistance with modifications to be purchased and installed in a vehicle owned by or a new vehicle purchased by the participant, or legally responsible parent of a minor or other caretaker.
- Non-warranty vehicle modification repairs; and
- Training on use of the modification.

The following as specifically excluded from VMS:

- Purchase or lease of new or used vehicles,
- General vehicle maintenance or repair, except upkeep and maintenance of the modifications.
- State inspections, insurance, gasoline, fines, tickets, or the purchase of warranties.
- Adaptations or improvements to the vehicle that are of general utility and are not of direct medical or remedial benefit to the individual.

Service Delivery Method *(check each that applies):*

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies):*

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Center for Independent Living
Individual	Non-KanCare Enrolled/Indirect Contractor
Individual	Individual Contractor (Direct Contractor)

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Vehicle Modification Services (VMS)

Provider Category:

Agency

Provider Type:

Center for Independent Living

Provider Qualifications

License *(specify):*

Certificate (*specify*):

Other Standard (*specify*):

- a. Enrolled in KanCare.
- b. Certificate of Worker's Compensation and General Liability Insurance
- c. Passing Background Checks consistent with the KDADS' Background Check policy
- d. Compliance with all regulations related to Abuse, Neglect, and Exploitation

Verification of Provider Qualifications

Entity Responsible for Verification:

Managed Care Organization, Center for Independent Living

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Vehicle Modification Services (VMS)

Provider Category:

Individual

Provider Type:

Non-KanCare Enrolled/Indirect Contractor

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

- This entity will subcontract with a Center for Independent Living, CILs perform the background checks.
- a. Affiliation with a Center for Independent Living
 - b. Certificate of Worker's Compensation and General Liability Insurance
 - c. Proof of business establishment for a minimum of two (2) consecutive years
 - d. Passing Background Checks consistent with the KDADS' Background Check policy
 - e. Compliance with all regulations related to Abuse, Neglect, and Exploitation

Verification of Provider Qualifications

Entity Responsible for Verification:

Managed Care Organization, Center for Independent Living

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Vehicle Modification Services (VMS)

Provider Category:

Individual

Provider Type:

Individual Contractor (Direct Contractor)

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

- a. Enrolled in KanCare
- b. Appropriately Licensed in Service
- c. Certificate of Worker's Compensation and General Liability Insurance
- d. Proof of business establishment for a minimum of two (2) consecutive years
- e. Passing Background Checks consistent with the KDADS' Background Check policy
- f. Compliance with all regulations related to Abuse, Neglect, and Exploitation.

Verification of Provider Qualifications

Entity Responsible for Verification:

Managed Care Organization, KMAP enrollment system, KDADS' background checks

Frequency of Verification:

Annual

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Wellness Monitoring

HCBS Taxonomy:

Category 1:

11 Other Health and Therapeutic Services

Sub-Category 1:

11010 health monitoring

Category 2:

11 Other Health and Therapeutic Services

Sub-Category 2:

11020 health assessment

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Wellness Monitoring is a process whereby a registered nurse evaluates the level of wellness of a participant to determine if the participant is properly using medical health services as recommended by a physician and if the health of the participant is sufficient to maintain him/her in the participant's place of residence without more frequent skilled nursing intervention.

Wellness Monitoring includes checking and/or monitoring the following:

1. Orientation to surroundings
2. Skin Characteristics
3. Edema
4. Personal Hygiene
5. Blood Pressure
6. Respiration
7. Pulse
8. Adjustments to medication

For members who access this service, the results will be included in information shared between the member's TCM and MCO care management staff.

The Registered Nurse providing the Wellness Monitoring will not also provide any services performed by a Personal Care Services provider to prevent duplicative billing with other services authorized on the Service Plan.

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

Participants must have medical conditions that require monitoring if they are not receiving skilled nursing care. Only one visit by a Registered Nurse, per 60 days, is covered.

Per the KanCare contracts the MCOs are responsible for ensuring the individual’s needs are met with a combination of waiver, State Plan and community resources. The MCO would ensure via the Person-Centered Service Plan and monitoring of the plan that the needs of the participant are being met.

A participant eligible for wellness monitoring lives in a non-institutional setting and, through the utilization of wellness monitoring is visited no more often than every 60 days, is able to maintain his/her independence at home, or in an alternative living arrangement. This service is provided by Registered Nurses only, who may be employed by home health agencies licensed by the Department of Health and Environment, KDADS licensed agencies, public health departments or Community Service Providers.

To avoid overlap of services, Wellness Monitoring service is limited to those services not covered through the Medicaid State Plan or other HCBS services and which cannot be procured from other formal or informal resources. Waiver funding shall be the funding source of last resort and requires prior authorization from the MCO via the participant's Person-Centered Service Plan. The services under the KS HCBS IDD Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization

Direct medical intervention is obtained through the appropriate medical provider and is not funded by this program.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Registered Nurse employed by a licensed HHA or Public Health Department

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Wellness Monitoring

Provider Category:

Agency

Provider Type:

Registered Nurse employed by a licensed HHA or Public Health Department

Provider Qualifications

License (specify):

- 1.An RN licensed by the Kansas Department of Health and Environment consistent with K.S.A. 65-5101 through K.S.A.65-5117, AND
- 2.An employee of a Home Health Agency as specified in K.S.A. 65-5101 through K.S.A. 65-5117 OR
- 3.An employee of a Public Health Department

Certificate (*specify*):

Other Standard (*specify*):

All HCBS providers are required to pass background checks consistent with the KDADS' Background Check Policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have a prohibited offense, as listed in K.S.A. 39-2009, is not eligible for reimbursement of services under Medicaid funding.

Providers must be an affiliate of the CDDO in the area in which the services are provided.

Verification of Provider Qualifications

Entity Responsible for Verification:

Managed Care Organizations in accordance with the Provider Qualification policy M2017-171.

Frequency of Verification:

The MCOs, with oversight by KDADS, shall verify provider qualifications annually.

Appendix C: Participant Services

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

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

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

Applicable - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

As a waiver service defined in Appendix C-3. *Do not complete item C-1-c.*

As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option). *Complete item C-1-c.*

As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c.*

As an administrative activity. *Complete item C-1-c.*

As a primary care case management system service under a concurrent managed care authority. *Complete item C-1-c.*

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

Targeted Case Managers (TCM):

1. are licensed by KDADS
2. are required to contract with the MCOs
3. are required to be enrolled Medicaid providers for Developmental Disabilities Targeted Case Management services
4. are required to affiliate with the CDDO in their area

Each individual case manager is required to have met the following education and training requirements:

- Six months full time experience in a field of human services; and
- A bachelor's degree; or additional full-time experience in the field of developmental disabilities services, which may be substituted for the degree at the rate of 6 months of full-time work experience for each missing semester of college; and
- Successful completion of the designated case management training and assessment by scoring eighty five percent or higher on each module.

The KanCare MCOs will work with the participant, the participant's TCM and the other persons in the participant's support planning team, to assist in the development of a Person-Centered Service plan that addresses the service and support needs across the participant's life and to assist the participant in identifying and accessing services and supports beyond I/DD waiver services. This is a part of the MCOs' administrative functions around care management and participant support within the KanCare program. The work of the MCO staff will supplement the effort of the participant's IDD waiver and TCM providers.

KDADS may grant an exception to the minimum requirements of a Targeted Case Manager on an individualized basis via a request by the CDDO. Exceptions could be granted for those who have not yet met the requirement for six months of service experience in the IDD field. If granted, the exception will be given in writing from KDADS to the CDDO. This exception will outline that the TMC will work under the direct supervision of a qualified TCM until the new TCM has had six months of experience. KDADS will maintain a log to track granted exceptions.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

- a. Criminal History and/or Background Investigations.** Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

No. Criminal history and/or background investigations are not required.

Yes. Criminal history and/or background investigations are required.

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Community Developmental Disability Organizations (CDDOs), Community Service Providers (CSPs), and all HCBS providers shall perform background checks in accordance with the KDADS' Background Check policy, and shall comply with all regulations related to Abuse, Neglect and Exploitation.

All HCBS providers are required to pass background checks consistent with the KDADS' Background Check Policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have a prohibited offense, as listed in K.S.A. 39-2009, is not eligible for reimbursement of services under Medicaid funding.

CDDOs and Community Service Providers (CSPs) are responsible for ensuring background checks are completed on their employees and employees of persons or families for whom they perform administrative duties. CDDOs and CSPs may require additional or follow-up background checks as they deem appropriate. Results of background checks must be available for review by authorized KDADS, CDDO, KDHE and KanCare MCO staff.

Background checks are required of employees regardless of whether they are providing a licensed or non-licensed service. KDADS regional Quality Enhancement staff review staff files as a part of their on-going provider review process.

The employer shall submit a request for the following checks:

1. a criminal record check through KDADS Health Occupation Credentialing (HOC)
2. a check for ANE through the Nurse Aid Registry
3. a driver's license record check through the Kansas Department of Revenue (KDOR) for those that drive Participants
4. an adult and child ANE check through Department of Children and Families (DCF)
5. a license, certification or registration verification through the applicable credentialing entity
6. an excluded entities and individuals check through the Office of the Inspector General (OIG)

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

No. The state does not conduct abuse registry screening.

Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

CDDOs, CSPs, and all HCBS providers shall perform background checks in accordance with the KDADS' Background Check policy.

All HCBS providers are required to pass DCF abuse registry checks consistent with the KDADS' Background Check Policy and comply with all regulations related to Abuse, Neglect and Exploitation.

CDDOs and CSPs, and all HCBS providers are responsible for ensuring background checks, which include abuse registry checks, are completed on their employees and employees of persons or families for whom they perform administrative duties. CDDOs, CSPs and all HCBS providers may require additional or follow-up background checks as they deem appropriate. Results of background checks must be available for review by authorized KDADS, CDDO, KDHE and KanCare MCO staff.

KDADS regional Quality Enhancement staff review staff files as a part of their on-going provider review process. As a part of the file review, Quality Management staff confirm that documentation is present that the person has passed the required abuse registry screenings.

All HCBS providers are required to pass ANE checks conducted by the following entities.

1. a check for ANE through the Nurse Aid Registry
2. an adult and child ANE check through Department of Children and Families (DCF)

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

Note: Required information from this page is contained in response to C-5.

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.

Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

A court appointed guardian or individual authorized as an A-DPOA may be paid to provide supports if the potential conflict of interest are mitigated. Natural guardians or spouses of waiver participants are not required to mitigate the conflict of interest. Participants should be educated by the MCO that they will be offered choice in caregivers and are not required to use any legally responsible individual unless the participant so chooses.

Services that may be furnished by a relative or legal guardian are limited to the scope, duration and amount determined by the MCO needs assessment and authorized in the participant's Person-Centered Service Plan.

Foster Care parents will be not be paid for providing waiver funded services.

Personal Care Services provided by a Court Appointed Legal Guardian:

- A court appointed legal guardian is not permitted to be a paid provider for the participant unless the probate court determines that all potential conflict of interest concerns have been mitigated in accordance with KSA 59-3068.
- a. It is the responsibility of the appointed guardian to report any potential conflicts to the court in the annual or special report as required by guardianship law and to maintain documentation regarding the determination of the court.
- b. A copy of the special or annual report in which the conflict of interest is disclosed will be provided to the MCO and FMS provider if along with the judge's order approving the annual or special report and determining that there is no conflict of interest for the guardian to be paid to provide supports for the participant under the HCBS program.
- 2. If the court determines that all potential conflict of interest concerns have not been mitigated, the legal guardian can:
 - a. Select someone (family member or friend) to provide the HCBS services to the participant. If a family member or friend is not available, the participant's selected MCO or FMS provider can assist the legal guardian in finding a direct support worker or seeking alternative HCBS service providers in the community; OR
 - b. Select someone (family member, friend) to appoint as a Designated Representative to develop the integrated Person-Centered Service Plan and direct the participant's services under HCBS.
- 3. An activated durable power of attorney (A DPOA who is currently authorized to make financial, medical or other decisions on behalf of the participant) is not permitted to be a paid provider for participant unless a Designated Representative is appointed to direct the individual's care (hire, fire, manage, training, and monitor direct support workers).

Personal Care Waiver Services provided for minors by Parents and/or Spouses.

Personal Care Services may be used to pay parents of minor enrollees under age (18) or spouses of enrollees. Parents of minors and spouses must meet the provider qualifications for this service.

For an enrollee's spouse or parent of a minor enrollee to be paid under the waiver, the service or support must meet all of the following authorization criteria and monitoring provisions. The service must:

- Meet the definition of a personal care services as outlined in the federal waiver plan.
- be specified in the individual's Person-Centered Service Plan
- be provided by a parent or spouse who meets the qualifications and training standards identified as necessary in the enrollees Person-Centered Service Plan;

The MCO needs assessment will be used to provide a means to identify activities in which the enrollee is dependent, to distinguish between activities that a parent or family member would ordinarily perform and those activities that go beyond what is normally expected to be performed, and to identify areas in which the level of assistance or supervision required exceeds what is typically required of a person of the same age. The needs assessment will be used to determine whether extraordinary care is required and may be provided by a spouse. To determine if extraordinary care is required and may be provided by a parent, the needs assessment for age appropriateness is completed.

- Completes training from the waiver participant or their representative utilizing the Personal Care Services checklist developed by the waiver participant and/or their representative and aided by their Care Coordinator as necessary. This document will be in kept in the person's home and be part of the Person-Centered Service Plan record and reviewed at least annually and updated as needed to indicate change in the participant's service needs.

In addition to the above:

- All employers must act in accordance with the Fair Labor Standards Act.
- All direct service workers including parents and spouses must utilize the EVV system for hours paid.
- Married enrollees must be offered a choice of providers. If they choose a spouse as their care provider, it must be documented in the Person-Centered Service Plan

Additional payment cannot be supplemented by the member or natural supports.

The Person-Centered Service Plan must state that the relative is the best available appropriate direct service worker for the person using services.

Since it is the intention of Overnight Respite to provide relief for the participant's family member who serves as an unpaid primary caregiver, the unpaid primary caregiver cannot be paid to provide Respite.

Self-directed

Agency-operated

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

The state does not make payment to relatives/legal guardians for furnishing waiver services.

The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

The State of Kansas does not prevent non-legally responsible relatives from providing PCS and ECS services. The non-legally responsible relatives are subject to the same requirements as detailed in the service definitions and provider qualifications in Appendix C.

The State of Kansas defines legally responsible individuals as: 1) the parent of a minor child; 2) a spouse of a waiver participant; 3) the court appointed guardian or activated DPOA of a waiver participant; 4) a foster parent.

KDADS allows legally responsible individuals to provide ECS under the following circumstances:

1. A court appointed legal guardian is not permitted to be a paid provider for the participant unless the probate court determines that all potential conflicts of interest have been mitigated in accordance with K.S.A. 59-3068.

a. It is the responsibility of the appointed guardian to report any potential conflicts to the court in the annual or special report as required by guardianship law and to maintain documentation regarding the determination of the court.

b. It shall be the responsibility for the legal guardian to provide to the MCO and FMS provider a copy of the special or annual report in which the conflict of interest is disclosed and a copy of the judge’s order or approval determining that there is no conflict of interest for the guardian to be paid to provide HCBS supports for the participant.

2. If the court determines that all potential conflicts of interest have not been mitigated; or the legal guardian otherwise chooses to provide personal care services, the legal guardian shall select a designated representative, who is not a legally responsible individual for the participant, to develop the Person-Centered Service Plan and direct the participant’s HCBS services.

3. An A-DPOA, who is currently authorized to make financial, medical or other decisions on behalf of the participant, is not permitted to be a paid provider unless a designated representative is appointed to direct the individual’s care.

4. The MCO may grant an exception to the above listed criteria when one of the three circumstances is present:

1) The participant lives in a rural area, in which access to a provider is beyond a 50 mile radius from the participant's residence and the relative or family member is the only provider available to meet the needs of the participant.

2) The participant lives alone and has a severe cognitive impairment, physical disability or intellectual disability

3) The participant has exhausted other support options offered by the MCO and absent services would be at significant risk of institutionalization.

The controls that are employed to ensure that payments are made only for services rendered include: MCO quarterly Quality Reviews to monitor that services that are provided are approved in the Person-Centered Service Plan, monitoring of services provided via the Electronic Visit Verification system, and other controls as described in Appendix I.

Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.

Specify the controls that are employed to ensure that payments are made only for services rendered.

Other policy.

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Kansas provides for continuous, open enrollment of waiver service provider by way of an online provider enrollment portal (see <https://www.kmap-state-ks.us/Public/provider.asp>). The online portal also contains training materials and other useful information that prospective providers may access at their convenience, including a tip sheet and provider enrollment training video. The adequacy of MCO provider networks is monitored quarterly via standardized reports submitted through the KanCare Reporting System. HCBS waiver program management staff are maintained on a report distribution list and notified when a new report submission is received. Whenever the number of providers falls below the established network adequacy threshold, the HCBS program manager works with the MCO and KDHE to develop an action plan for achieving the required threshold.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

- a. *Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of newly enrolled licensed/certified waiver provider organizations that met all license and certification requirements and other standards

N=Number of newly enrolled licensed/certified waiver provider organizations that met licensure/certification requirements and other standards. D=Number of newly enrolled licensed/certified waiver provider organizations reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record Review

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100%

		Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = 95%; +/- 5% margin of error. The state conducts a representative sample against a pool of providers that includes both enrolled licensed/certified as well as non-licensed/certified providers
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Number and percent of enrolled licensed/certified waiver provider organizations that continue to meet all license and certification requirements & other standards
N=Number of enrolled licensed/certified waiver provider organizations that continue to meet all licensure/certification requirements & other standards D=Number of enrolled licensed/certified waiver provider organizations reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record Review

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =

		95%; +/- 5% margin of error The state conducts a representative sample against a pool of providers that includes both currently enrolled licensed/certified as well as non-licensed/certified providers
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Continuously and Ongoing
	Other Specify: <input type="text"/>

b. Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of newly enrolled non-licensed/non-certified waiver provider organizations that met all waiver requirements and other standards N=Number of newly enrolled non-licensed/non-certified waiver provider organizations that met all waiver requirements and other standards D=Number of newly enrolled non-licensed/non-certified waiver provider organizations reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record Review

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =

		95%, +/- 5% margin of error The state conducts a representative sample against a pool of providers that includes both newly enrolled licensed/certified as well as non-licensed/certified providers
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

Number and percent of enrolled non-licensed/non-certified waiver provider organizations that continue to meet all waiver requirements and other standards
N=Number of enrolled non-licensed/non-certified waiver provider organizations that continue to meet waiver requirements and other standards
D=Number of enrolled non-licensed/non-certified waiver provider organizations reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Managed Care Organization (MCO) reports and record reviews

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> 95%, +/- 5% margin of error. The state conducts a representative sample to a pool of providers that includes both newly enrolled licensed/certified and non-licensed/certified providers </div>

<p>Other Specify:</p> <div style="border: 1px solid black; padding: 5px; width: fit-content;"> KanCare Managed Care Organizations (MCOs) </div>	<p>Annually</p>	<p>Stratified Describe Group:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<p>Continuously and Ongoing</p>	<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<p>State Medicaid Agency</p>	<p>Weekly</p>
<p>Operating Agency</p>	<p>Monthly</p>
<p>Sub-State Entity</p>	<p>Quarterly</p>
<p>Other Specify:</p> <div style="border: 1px solid black; padding: 5px; width: fit-content;"> KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency </div>	<p>Annually</p>
	<p>Continuously and Ongoing</p>
	<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

c. Sub-Assurance: *The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.*

For each performance measure the State will use to assess compliance with the statutory assurance,

complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of active providers that meet training requirements N=Number of active providers that meet training requirements D=Number of providers reviewed Workplan for 7/1/25

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record Review

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = 95% confidence level; +/- 5% margin of error.
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/> Proportionate by MCO
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify:	

	<input style="width: 80%; height: 30px;" type="text"/>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 30px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 30px;" type="text"/>

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through a state interagency monitoring process, which includes program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

b. Methods for Remediation/Fixing Individual Problems

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

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

ii. **Remediation Data Aggregation**

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;"> KanCare Managed Care Organizations (MCOs) </div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

For sub-assurance C, the State has begun identifying the training requirements of active providers. It will implement a training program to begin training providers in the 3rd quarter of 2025 and will begin measuring the PM in the 4th quarter.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

Not applicable- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Applicable - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect

when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. *(check each that applies)*

Limit(s) on Set(s) of Services. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.

Furnish the information specified above.

Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.

Furnish the information specified above.

Budget Limits by Level of Support. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.

Furnish the information specified above.

Other Type of Limit. The state employs another type of limit.

Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCBS Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

In HCBS settings for Intellectual/Developmental Disabilities (I/DD) participants, the participant will have:

- A lease or a written agreement with eviction and appeals rights
- Choice of settings and roommates based on their needs, preferences, and resources
- Choice of services and supports, and who provides
- Rights of privacy (lockable doors), dignity, respect, and freedom from coercion and restraint
- Right to control personal resources and make money in a job in the community
- Support for choice of daily activities, physical environment, and with whom to interact
- Freedom and support to control their own schedules, activities, and access food at any time
- Right and ability to have visitors of their choosing at any time
- A setting that is physically accessible, including ADA compliant
- Any limit or restriction supported by a specific assessed need, evaluated frequently, and be approved by the participant, parent or guardian

Settings:

1. Apartment/Private Residence
2. Family Home
3. IDD Residential group home
4. Host Home/Licensed Foster Home
5. Other community setting

The process that the state Medicaid agency used to assess and determine that all waiver settings meet the HCB settings requirements:

The state Medicaid agency will not allow a provider to enroll or revalidate their enrollment until the Operating Agency conducts an HCBS Readiness Assessment, involving a Provider Readiness Assessment and a Settings Heightened Scrutiny review for provider-owned, managed, and/or controlled settings. Providers must demonstrate compliance through documentation, policies, and manuals. The settings are reviewed for compliance with HCB settings requirements, and non-compliant providers must submit a remediation plan or face transition proceedings and FFP recoupment.

The process that the state Medicaid agency will use to ensure that all settings will continue to meet the HCB settings requirements in the future:

The Operating agency will conduct ongoing monitoring through the HCBS Compliance Portal, requiring annual recertification and reassessment upon changes in service delivery. Regular onsite visits, quality oversight reviews, and reports from participants or other entities ensure continuous compliance. Providers must maintain up-to-date documentation and training records, and KDADS will provide training and guidance for remediation of identified non-compliance.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Person Centered Service Plan

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

Registered nurse, licensed to practice in the state

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

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

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

Case Manager (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

Kansas has contracted with Managed Care Organizations (MCOs), to provide overall management of Home and Community-Based Services (HCBS) services as one part of the comprehensive KanCare program. The MCOs are responsible for development of the Person-Centered Service Plan (Service Plan) in accordance with KDADS' Person-centered Service Plan policy. The MCO or their designee will use their staff to provide that service.

The CONTRACTOR(S) service coordinators shall have experience that is appropriate to the Member's health care needs and shall perform activities within their scope of practice in accordance with applicable licensing/credentialing rules. The CONTRACTOR(S) has the flexibility to determine the service coordinator qualifications for populations not specifically listed here. Service coordinators working with specific populations shall have specific qualifications. CONTRACTOR(S) and community service coordinators serving Members who are in multiple population groups, such as youth in foster care who are enrolled on a HCBS Waiver, shall be assigned service coordinator most appropriate for the Member's needs and have experience working with the populations to be served.

At minimum qualifications shall include:

A. For Members with a LTSS need, CONTRACTOR(S) and community service coordinators shall:

1. Have at least a bachelor's degree in social work, rehabilitation, nursing, psychology, special education, gerontology, or related health and human services area or be a Registered Nurse (RN).
2. Have at least one (1) year of experience working with individuals with long-term care needs, and if working with a specific Waiver population (e.g. IDD, TBI or Frail Elderly [FE]), at least one (1) years' experience working directly with that population. Full-time experience in the field of developmental disabilities services may be substituted for the degree at the rate of six (6) months of full-time experience for each missing semester of college for service coordinators working with individuals with IDD. Additionally, community service coordinators providing services to individuals with IDD must meets qualifications described in K.A.R. 30-63-32-Article 63.
3. Comply with additional qualifications as described in the State's HCBS Waivers included in Attachment C of this RFP.

B. For Members with a Behavioral Health need, CONTRACTOR(S) and community service coordinators shall:

1. Have at least a bachelor's degree in social work, nursing, rehabilitation, psychology or related health and human services area, or be a RN.
2. Have at least one (1) year of experience working with individuals with Behavioral Health needs and receive training in trauma informed care.

C. For youth in custody through the foster care system, CONTACTOR(S) and community service coordinators shall:

1. Have at least a bachelor's degree in social work, nursing, psychology or related health and human services area or be a RN.
2. Have at least one (1) year of experience working with individuals with multi-system children.
3. Receive training in trauma informed care.

Social Worker

Specify qualifications:

Other

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Case management services for participants on the IDD Waiver are provided by individuals employed by entities annually licensed by the Kansas Department for Aging and Disabilities Services that are also enrolled Medicaid providers for Developmental Disabilities Targeted Case Management services. Each individual case manager is required to have met the following education and training requirements:

- Six months full time experience in a field of human services; and
- A bachelor's degree; or additional full-time experience in the field of developmental disabilities services, which may be substituted for the degree at the rate of 6 months of full-time experience for each missing semester of college; and
- Successful completion of the designated case management training and assessment by scoring eighty five percent or higher on each module.

Consistent with the Developmental Disabilities Reform Act of 1995 and further with K.A.R. 30-63-21, the provider(s) of services shall prepare a written person-centered support plan for each person served that shall meet the following requirements.

The relevant requirements are:

1. Be developed only after consultation with the following:

A) The participant;

B) The participants' legal guardian, if one has been appointed, and;

C) Other individuals from the participants' support network as the person or the persons' guardian chooses.

2. Contain a description of the persons' preferred lifestyle.

3. The plan must list and describe the necessary activities, training, materials, equipment, assistive technology and services that are needed to assist the participant to achieve the participant's preferred lifestyle. The participant's case manager will be responsible for coordination of the plan.

All participants have the opportunity, to the extent he/she chooses, to participate in the development of his/her person-centered plan. The CDDO is responsible for informing the participant of the types of waiver services available in the CDDO area and a list of all of the providers of those services. The participant's case manager is responsible for and assisting the participant in his/her effort to meet with waiver providers to discuss how the provider can meet the participants' needs. In addition, the case manager is responsible for informing the participant of training opportunities that are available to assist the participant in becoming more active in his/her role in the planning process to the extent that he/she chooses.

Training topics would include:

- Person-centered planning models
- Self-Advocacy and;
- Rights and Responsibilities

A complete copy of K.A.R. 30-63-21 is available to CMS upon request.

The KanCare MCOs will work with the participant, the participant's TCM and the other people on the participant's support planning team, to assist in the development of an integrated service plan that addresses the service and support needs across the participant's life and to assist the participant in identifying and accessing services and supports beyond the IDD waiver services.

This will be a part of the KanCare MCOs' administrative functions around care management and member support within the KanCare program.

The Person-Centered Planning process includes the development of the Person-Centered Service Plan and the Person-Centered Support Plan, Individualized Education Plan, Behavior Management and Support Plan, Emergency Backup Plan, and other plans that are designed to identify the needs of a participant and determine the appropriate level of supports and services to meet those needs. Information from the person-centered planning process will be incorporated in the MCO's Service Plan. The process also includes the development of future goals and indication of preferred lifestyle choices, which are identified and included in the Person-Centered Support Plan, which is developed by a participant's Targeted Case Manager (TCM) in conjunction with the participant and their support team, including the individual's MCO.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

- d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing

information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The Person-Centered Service Plan process and expectations are outlined in the KDADS' Person-Centered Service Plan policy.

a) MCOs may use contracted entities to assist in the development and monitoring of the Person-Centered Service Plan (Service Plan) but has primary responsibility for Service Plan development and accountability to deliver all Medicaid covered services included in a participant's Service Plan. The initial and annual Service Plans are developed during a face-to-face meeting with the participant, legal representative (if applicable), the MCO and selected representatives that the participant chooses to be involved. Date and time of the Service Plan meeting is coordinated based on the convenience of the participant and the participant's representative, if applicable. The participant has the authority to determine the parties that he/she chooses to be involved in the development of their Service Plan. The KDADS' IDD Person-Centered Service Plan policy outlines who the required participants are in the development of the Service Plan. The Targeted Case Manager (TCM) is required to invite known HCBS providers for the individual to the Service Plan meeting unless otherwise specified by the individual. The TCM is responsible for notifying all parties authorized by the participant of the date, time, and location of the Service Plan meeting. If the participant has a court appointed guardian/conservator or an activated durable power of attorney for health care decisions, the guardian/conservator or the holder of the activated durable power of attorney for health care decisions must be included and all necessary signatures documented on the Service Plan.

The Service Plan is valid for 365 days from the date of the participant's and/or legal representative's signature unless there is a change in condition that requires an update to the Service Plan as detailed in the IDD Person-Centered Service Plan policy.

b) All applicants for program services must undergo a functional eligibility assessment to determine functional eligibility for the IDD waiver. The MFEI I/DD is utilized to determine the level of care (LOC) eligibility for the IDD waiver. To ensure there is no disruption in waiver eligibility, scope, or duration of service during the transition period (ARP MOE Period) KDADS will reassess any current/active waiver participant found ineligible on the new InterRAI-based assessment (MFEI I/DD) using the previous (legacy) BASIS tool. If the legacy tool (the BASIS) finds the participant eligible, KDADS will sustain the functional eligibility of the participant. If participant is found ineligible with the MFEI I/DD and the BASIS, current waiver language regarding appeal rights will apply. This approach will extend throughout the ARP MOE Period. The CDDO conducts an assessment of the individual within the timeframe specified in the contract, unless a different timeframe is requested by the applicant or his/her legal representative, if appropriate. The MCO, or their designee, will complete a needs assessment for the participant that will identify the services the participant needs in order to allow them to safely remain in the community and to help them achieve their preferred lifestyle. The participant with assistance from the TCM will complete a Person-Centered Support Plan (Support Plan). The Support Plan is a Service Plan related document which allows the participant to identify their preferred lifestyle, their strengths, their passions and values, what is important to them, their goals, areas in which they feel they need support and how they would like that support to be provided to them. The MCO, or their designee, will review the Support Plan with the individual and their legal representative during the Service Plan meeting and will use the Support Plan to help design the Service Plan. The Service Plan includes the scope, duration and amount of the authorized services for the HCBS participant.

c) Each participant found eligible for IDD waiver services can choose whether they would like to receive services through the waiver program. The MCO, or their designee, is responsible for providing information about the waiver service that are available to the participant. The participant, MCO, or their designee, and authorized legal representative work together to determine the services that best fit the needs of the participant. Participants are given free choice of all agency and self-directed, qualified providers for each applicable service included in the Person-Centered Service Plan (Service Plan). The MCO, or their designee, assists the participant with accessing information and supports from the participant's chosen provider.

d) Through the various assessments and Service Plan related documents described in b) above, the participant's goals, needs and preferences are at the forefront of developing their Service Plan. Reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the participant's disability. Additional meetings may be necessary due to changes in condition or circumstances. A meeting to update the Service Plan shall occur in accordance with the IDD Person-Centered Service Plan policy.

e) The Person-Centered Service Plan (Service Plan) is coordinated according to the process outlined in the KDADS' IDD

Person- Centered Service Plan policy. Additional coordination requirements are specified in the KanCare contract between the State and the MCOs. The MCO, or their designee, coordinates other federal and state program resources in the development of the Service Plan.

f) The responsibilities for implementing and monitoring delivery of services as authorized in the Service Plan are detailed in the IDD Person-Centered Service Plan policy and the HCBS Quality Review Policy. The participant's TCM monitors progress toward achieving the goals in the Person-Centered Service Plan. The TCM will make referrals for additional resources as needed. If there is a change in need, the TCM coordinates with the MCO to update and revise the Person-Centered Service Plan. The MCO Care Coordinator monitors delivery of the services authorized in the Person-Centered service plan through a series of face-to-face visits and phone calls.

g) The requirements for how and when the Service Plan are updated are specified in the KDADS' IDD Person-Centered Service Plan policy. The MCOs conduct periodic reviews, as specified by the KanCare MCO contracts, to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the participant's disability. Additional meetings may be necessary due to changes in condition or circumstances. A meeting to update the Service Plan shall occur in accordance with the IDD Person-Centered Service Plan policy.

Appendix D: Participant-Centered Planning and Service Delivery

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

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The participant's Person-Centered Service Plan (Service Plan) takes into account information from the Functional Eligibility Instrument and the MCO needs assessment which identifies potential risk factors. The Person-Centered Service Plan will document, at a minimum, the types of services to be furnished, the amount, frequency, and duration of each service, and the type of provider to furnish each service, including informal services and providers. The Person-Centered Service Plan identifies the support and services provided to the participant that are necessary to minimize the risk of institutionalization and ensure the health and welfare needs of the participants are being met. The Person-Centered Support Plan (Support Plan), a document that is a part of the Service Plan, describes, in the participant's own words, how the participant would like their supports to be provided. This includes any interventions that are identified as necessary to mitigate risk to the participant's health safety and welfare (Support Plan Risk Assessment & Intervention Plans).

Reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the participant's disability. Additional meetings may be necessary due to changes in condition or circumstances. A meeting to update the Service Plan shall occur in accordance with the IDD Person-Centered Service Plan policy.

A back-up plan for each individual is established during the needs assessment and Person-Centered Service Plan development. This and other information from the assessment and annual re-assessment are incorporated into a backup plan which is utilized to mitigate risk related to extraordinary circumstances. Backup plans are developed according to the unique needs such as physical limitations and circumstances, such as the availability of informal supports of each participant. Backup arrangements are added to Service Plans and identify key elements, including specific strategies and contact individuals.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The Developmental Disabilities Reform Act (DDRA) of 1995 specifies in section 39-1805 the duties of a Community Developmental Disability Organization (CDDO) to provide either directly or by subcontract, services to persons with a developmental disability including, among other things, an explanation to the participant of the available services and service providers in the CDDO area.

The CDDO, per K.A.R. 30-64-23, acts as the single point of application, determination, and referral for impartial information regarding the types and availability of community services within the service area and of the licensed providers and other agencies existing within the service area.

Participants receiving services will be advised of the available community service providers in the CDDO area on at least an annual basis and also when requested by the participant. This may be done in a variety of ways including lists which are updated on a regular basis or through the CDDOs website. Options counseling is documented by the CDDO and kept on file.

Once a participant is made aware of the services available and the providers of services in the area, the participant's case manager will assist him/her in meeting with and touring services provided. It becomes the case manager's role to facilitate, the participant and the participant's guardian if one has been appointed, through a process that ends with the participant choosing a provider of services that can meet the participant's support needs.

KDADS will provide a provider capacity map by CDDO catchment area that demonstrates access to services and provider capacity to meet identified needs. If a need for additional capacity is identified, the CDDO will provide a capacity development plan and work with the MCO to provide incentives to attract new providers as necessary.

If needed, the MCO will provide alternate temporary services while that capacity is developed.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

Oversight of the service plans by the Medicaid Agency is completed through the following strategies. One waiver quality strategy is the following process is utilized and reported quarterly to the KDHE LTC.

A representative sample of HCBS Waiver individual's case files, to include National Core Indicators (NCI surveys), will be selected quarterly by KDADS' Financial and Information Services Commission (FISC), and assigned to the appropriate Quality Management Specialist (QMS) for review. The selected cases will include both Primary (P) and Secondary (S) listing of cases. Record cases open for 30 days or less, from MMIS eligibility date, are considered a "non-review" and will not be reviewed by QMS. A secondary case will be substituted when the case is deemed a "non-review."

Case specific documentation for Quality Reviews shall be completed by desk review or provider's on-site location. For desk reviews, file documentation should be uploaded in the systems of record, to include but not limited to the Quality Review Tracker (QRT) by the MCO's and KAMIS by the Assessor's. QMS will review documentation by using the established protocols. For on-site reviews, file documentation uploaded by the MCO's and/or Assessor's, will be reviewed by QMS using the established protocols at the designated provider locations. Findings for desk and on-site reviews will be recorded in Quality Review Tracking system (QRT) for the MCO/Assessor's remediation.

Data analysis is completed and remediated for any assurance or sub-assurance less than 86%. KDADS staff will notify the provider of areas below 86% with details of each finding. The provider will be required to respond to the notification for remediation within 15 business days detailing their plan for correction. The plan will be reviewed by KDADS staff for approval of the plan. Should the plan not be approved, the provider will be notified and asked to resubmit an acceptable plan of correction. Once the remediation plan is approved, with a timeline for compliance, KDADS staff will continue to monitor through Quality Reviews to ensure compliance.

Any abuse, neglect or exploitation issue will be immediately reported to the designated state reporting agency. Any substantiated case of ANE will require remediation. The remediation plan must address how health and safety needs have been addressed including immediate corrective action and ongoing plan to prevent ANE.

Findings or concerns on a specific case identified through the review by QMS will be entered in QRT. Once entered, the QRT system will send an alert to the Assessor and/or MCO, and copy to the applicable Program Manager.

KDADS estimates the statistical range of values within which the true target population is likely to fall, and how certain we can be that the true population value is within the range of values. The sample sizes prepared for the quality review team use a probability sample method, using a multi-stage, stratified sample.

- The sample size is determined by total waiver population, or with some measures, the total population of those waiver members with whom the measure is applicable (example, some measures are only applicable to new waiver eligibles only).
- In respect to the degree of accuracy, the random samples are prepared with a 95% confidence level that the confidence interval of each measure (the measure metric) meets the standard denoted in each measure, with a +/-5% margin of error.
- KDADS oversample by 30%, to insure the output the quality review team submits for reporting meets the 95% confidence level requirements of each waiver population and measure.

KDHE also contracts for EQRO to review a sample of service plans annually for each waiver. The PPOC is reviewed for new waiver participants by KDHE.

Appendix D: Participant-Centered Planning and Service Delivery

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

- h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

Every three months or more frequently when necessary

Every six months or more frequently when necessary

Every twelve months or more frequently when necessary

Other schedule

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

- Medicaid agency**
- Operating agency**
- Case manager**
- Other**
Specify:

Service plans and related documentation will be maintained by the participant's chosen KanCare MCO, local Community Developmental Disability Organization and the persons' Community Service Providers and will be retained at least as long as this requirement specifies, as well as per policy and contract.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The KanCare contracting managed care organizations are responsible for monitoring the implementation of the Person-Centered Service Plan that was developed as a partnership between the participant, participant's responsible party (if participant has responsible party), TCM, participant's team, and the MCO and for ensuring the health and welfare of the participant with input from the IDD Program Manager, involvement of KDADS Regional Field Staff, and assessed with the comprehensive statewide KanCare quality improvement strategy (which includes all of the HCBS waiver performance measures).

On an ongoing basis, the MCOs monitor the Person-Centered Service Plan and participant needs to ensure:

- Services are delivered according to the Person-Centered Service Plan;
- Participants have access to the waiver services indicated on the Person-Centered Service Plan;
- Participants have free choice of providers and whether or not to self-direct their services;
- Services meet participant's needs;
- Liabilities with self-direction/agency-direction are discussed, and back-up plans are effective;
- Participant's health and safety are assured, to the extent possible; and
- Participants have access to non-waiver services that include health services."

The Person-Centered Service Plan is the fundamental tool by which the State will ensure the health and welfare of participants served under this waiver. The KanCare MCOs, who deliver no direct waiver services to waiver participants, are responsible for both the initial and updated plans of care.

In-person monitoring by the MCOs is ongoing:

- Choice and monitoring are offered at least annually, regardless of current provider or self-direction, or at other life choice decision points, or any time at the request of the participant.
- Choice is documented.
- The Person-Centered Service Plan is modified to meet change in needs, eligibility, or preferences, or at least annually."

In addition, the Person-Centered Service Plan and choice are monitored by state quality review and/or performance improvement staff as a component of waiver assurance and minimum standards. Issues found needful of resolution are reported to the MCO and waiver provider for prompt follow-up and remediation. Related information is reported to the IDD Program Manager.

Service plan implementation and monitoring performance measures and related collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through the KanCare QI Strategy, which includes HCBS waiver program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

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

The CDDOs also assist the participant in identifying service providers in their region who may provide the type of service the participant is seeking.

b. Monitoring Safeguards. *Select one:*

Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Established safeguards include informal on-going review processes in place and conducted by KDADS Regional Field Staff, and more formal review through the National Core Indicators (NCI) survey.

The CDDOs also have a regulatory role for quality enhancement and quality assurance (K.A.R. 30-64-26 and K.A.R. 30-64-27, respectively).

The primary responsibilities for service plan monitoring lies with the KanCare MCOs and the participant’s targeted case manager who are both prohibited from providing any direct service to the participant.

The Targeted Case Manager has a regulatory duty for monitoring and follow-up to ensure that the person-centered support plan and related supports and services are effectively implemented and adequately addressing the needs of the person (K.A.R. 30-63-32).

In addition, the safeguards in place for all other Medicaid providers apply to all Medicaid-enrolled Financial Management (FMS) agencies.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

- a. *Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of waiver participants whose service plans address health and safety risk factors
N=Number of waiver participants whose service plan address health and safety risk factors
D=Number of waiver participants whose service plans were reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

Responsible Party for data	Frequency of data collection/generation	Sampling Approach <i>(check each that applies):</i>
----------------------------	---	--

collection/generation <i>(check each that applies):</i>	<i>(check each that applies):</i>	
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = 95% confidence level; +/- 5% margin of error.
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: Proportionate by MCO
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="text"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Number and percent of waiver participants whose service plans address participants' goals N=Number of waiver participants whose service plans addresses the participant's goals D=Number of waiver participants whose service plans were reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/> 95% confidence level; +/- 5% margin of error.
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/> Proportionate by MCO
	Continuously and	Other

	Ongoing	Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Number and percent of waiver participants whose person-centered service plans address their assessed needs and capabilities as indicated in the assessment
N=Number of waiver participants whose service plan address their assessed needs and capabilities as indicated in the assessment D=Number of waiver participants whose service plans were reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

Responsible Party for data	Frequency of data collection/generation	Sampling Approach (<i>check each that applies</i>):
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collection/generation <i>(check each that applies):</i>	<i>(check each that applies):</i>	
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px;">95% confidence level; +/- 5% margin of error.</div>
Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; padding: 2px;">Proportionate by MCO</div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px;"></div>
	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input type="checkbox"/>	
	Continuously and Ongoing
	Other Specify: <input type="checkbox"/>

b. Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of person-centered service plans (initial and annual updates) signed and dated within state required timeframes N=Number of person-centered service plans (initial and annual updates) signed and dated within state required timeframes D=Number of waiver participants whose service plans were reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record Review

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;"> 95% confidence level; +/- 5% margin of error </div>
Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px 0;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; padding: 2px; width: fit-content;"> Proportionate by MCO </div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px 0;"></div>
	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px 0;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input type="text"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Number and percent of waiver participants whose service plan was revised, as needed, to address a change in need $N = \text{Number of waiver participants whose service plan was revised, as needed, to address a change in need}$ $D = \text{Number of waiver participants whose service plans were reviewed}$

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record Review

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text" value="95% confidence level; +/- 5% margin of error"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text" value="Proportionate to MCO"/>

	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

d. Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

and % of waiver participants who received services and supports as authorized in their service plans including type, scope, amount, duration, and frequency

N=Number of waiver participants who received services and supports as authorized in their service plans including type, scope, amount, duration, and frequency

D=Number of waiver participants whose service plans were reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record Review

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;"> 95% confidence level; +/- 5% margin of error. </div>
Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; padding: 2px; width: fit-content;"> Proportionate by MCO </div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

e. *Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care
N = Number of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care
D = Number of waiver participants whose service plans were reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record Review

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

State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;"> 95% confidence level; +/- 5% margin of error. </div>
Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px 0;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; padding: 2px; width: fit-content;"> Proportionate by MCO </div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px 0;"></div>
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin: 5px 0;"></div>	Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Number and percent of waiver participants whose record contains documentation indicating a choice of waiver services N=Number of waiver participants whose record contains documentation indicating a choice of waiver services D=Number of waiver participants whose service plans were reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record review

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/> 95% confidence level; +/- 5% margin of error.
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/> Proportionate by MCO
	Continuously and Ongoing	Other Specify:

		<input type="checkbox"/>
	<p>Other Specify:</p> <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
<p>Other Specify:</p> <input type="text"/>	Annually
	Continuously and Ongoing
	<p>Other Specify:</p> <input type="text"/>

Performance Measure:

Number and percent of waiver participants whose record contains documentation indicating a choice of waiver service providers
 $N = \text{Number of waiver participants whose record contains documentation indicating a choice of waiver service providers}$
 $D = \text{Number of waiver participants whose service plans were reviewed}$

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record review

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
---	--	--

State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;"> 95% confidence level; +/- 5% margin of error. </div>
Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; padding: 2px; width: fit-content;"> Proportionate by MCO </div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	Annually

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Kansas Department of Health and Environment, Division of Health Care Finance (KDHE), the single state Medicaid agency, and Kansas Department for Aging and Disability Services (KDADS) work together to develop state operating agency priority identification regarding all waiver assurances and minimum standards/basic assurances. The state agencies work in partnership with participants, advocacy organizations, provider groups and other interested stakeholders to monitor the state quality strategy and performance standards and discuss priorities for remediation and improvement. The state quality improvement strategy includes protocols to review cross-service system data to identify trends and opportunities for improvement related to all Kansas waivers, policy and procedure development and systems change initiatives.

Data gathered by KDADS Regional Staff during the Quality Survey Process, and data provided by the KanCare MCOs, is compiled quarterly for evaluation and trending to identify areas for improvement. Upon completion of identified areas of improvement this information is compiled into reports and shared both internally and externally, including with KDHE. MCO staff from the three plans will be engaged with state staff to ensure strong understanding of Kansas’ waiver programs and the quality measures associated with each waiver program. Over time, the role of the MCOs in collecting and reporting data regarding the waiver performance measures will evolve, with increasing responsibility once the MCOs fully understand the Kansas programs. These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through state interagency monitoring, which includes program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

b. Methods for Remediation/Fixing Individual Problems

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

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

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

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;"> KanCare Managed Care Organizations (MCOs) </div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request):*

Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.

No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

Yes. The state requests that this waiver be considered for Independence Plus designation.

No. Independence Plus designation is not requested.

Appendix E: Participant Direction of Services

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

a) All participants of IDD waiver services have the opportunity to choose the MCO that will support them in overall service access and care management. The opportunity for participant direction (self-direction) is made known to the participant by the MCO, which is available to all waiver participants (Kansas Statute 39-7,100).

This opportunity includes specific responsibilities required of the participant, including:

- Recruitment and selection of providers;
- Assignment of service provider hours within the limits of the authorized services;
- Complete an agreement with an enrolled Financial Management Services (FMS) provider;
- Referral of providers to the participant's chosen FMS provider;
- Provider orientation and training;
- Maintenance of continuous service coverage in accordance with the Person-Centered Service Plan, including assignment of replacement workers during vacation, sick leave, or other absences of the assigned attendant;
- Verification of hours worked and assurance that time worked is forwarded to the FMS provider;
- Other monitoring of services; and
- Dismissal of the worker, if necessary.

b) Participants are provided with information about self-direction of services and the associated responsibilities by the MCO during the service planning process. Once the participant is deemed eligible for waiver services, the option to self-direct is offered and, if accepted, the choice is indicated on a Participant Choice form and included in the participant's Person-Centered Service Plan.

The MCO assists the participant with identifying an FMS provider and related information is included in the participant's Person-Centered Service Plan. The MCO supports the participant who selects self-direction of services by monitoring services to ensure that they are provided by Personal Care Attendants and Enhanced Care Services attendants in accordance with the Person-Centered Service Plan and the Attendant Care Worksheet, which are developed by the participant with assistance from the MCO. The MCO also provides the same supports given to all waiver participants, including Person-Centered Service Plan updates, referral to needed supports and services, and monitoring and follow-up activities.

c) The FMS Kansas Medical Assistance Program (KMAP) manual and State policy detail the responsibilities of the FMS provider. FMS support is available for the participant (or the person assigned by the participant, such as a representative, family member, parent, spouse, adult child, guardian) who has chosen to self-direct some or all services, to assist the participant by performing administrative and payroll functions. FMS support will be provided within the scope of the Employer Authority model. The FMS is available to participants who reside in their own private residences or the private home of a family member and have chosen to self-direct their services. FMS assists the participant or participant's representative by providing two distinct types of tasks: (1) Administrative Tasks and (2) Information and Assistance (I & A) Tasks. The FMS provider is also responsible for informing the participant that he/she must exercise responsibility for making the choice to self-direct his/her services, understand the impact of the choices made, and assume responsibility for the results of any decisions and choices that were made. The FMS provider is responsible for clearly communicating verbally and in writing the participants responsibilities relating his/her role as an employer of a direct service worker.

The FMS provider is responsible for certain administrative functions, tasks include, but are not limited to, the following:

- Verification and processing of time worked and the provision of quality assurance;
- Preparation and disbursement of qualified direct support worker payroll in compliance with federal, state and local tax; labor; and workers' compensation insurance requirements; making tax payments to appropriate tax authorities;
- Performance of fiscal accounting and expenditure reporting to the participant or participant's representative and the state, as required.
- Assistance to ensure the basic minimum qualifications set by the State are met in order to ensure participant safety, health and welfare.

The FMS provider is responsible for Information and Assistance functions including but not limited to:

1. Explanation of all aspects of self-direction and subjects pertinent to the participant or participant's representative in managing and directing services;
2. Assistance to the participant or participant's representative in arranging for, directing and managing services;
3. Assistance in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services;
4. Offers practical skills training to enable participants or representatives to independently direct and manage waiver services such as recruiting and hiring direct service workers (DSW), managing workers, and providing effective communication and problem-solving.

d) For all health maintenance activities, the participant shall obtain a completed Physician/RN Statement to be signed by an attending physician or registered professional nurse. The statement must identify the specific activities that have been authorized by the physician or registered professional nurse. The MCO is responsible to ensure that the Physician/RN Statement is completed in its entirety.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver.
Select one:

Participant: Employer Authority. As specified in *Appendix E-2, Item a*, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.

Participant: Budget Authority. As specified in *Appendix E-2, Item b*, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

Both Authorities. The waiver provides for both participant direction opportunities as specified in *Appendix E-2*. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.

Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.

The participant direction opportunities are available to persons in the following other living arrangements

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy (*select one*):

Waiver is designed to support only individuals who want to direct their services.

The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.

The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.

Specify the criteria

Participants on this waiver or legal guardian on the participant's behalf may direct some or all of the services offered under participant-direction. Participant-direction is offered for the following services:

- ECS
- FMS
- Overnight Respite
- PCS

Self-direction is not an option when the participant/legal guardian has been determined to have been documented as demonstrating the inability to participant-direct the direct service workers, resulting in fraudulent activities; confirmation of abuse, exploitation or medical neglect. Any decision to restrict or remove a participant's direction opportunity will be referred by the MCO to KDADS for concurrence of action and is subject to the grievance and appeal protections detailed in Appendix F.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

- e. Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

a) Participants are informed that, when choosing participant direction (self-direction) of services, they must exercise responsibility for making choices about services provided by direct service workers, understand the impact of the choices made, and assume responsibility for the results of any decisions and choices they make. Participants are provided with, at a minimum, the following information about the option to self-direct services:

- the services covered and limitations;
- the need to select and enter into an agreement with an enrolled Financial Management Services (FMS) provider;
- related responsibilities (outlined in E-1-a);
- potential liabilities related to the non-fulfillment of responsibilities in self-direction;
- supports provided by the managed care organization (MCO) they have selected;
- the requirements of direct service workers;
- the benefits of self-direction;
- the ability of the participant to choose not to self-direct services at any time; and
- other situations when the MCO may discontinue the participant's participation in the self-direct option and recommend agency-directed services.

b) The MCO is responsible for sharing information with the participant about self-direction of services by the participant. The FMS provider is responsible for sharing more detailed information with the participant about self-direction of services once the participant has chosen this option and identified an enrolled provider. This information is also available from the IDD Program Manager, KDADS Regional Field Staff, and is also available through waiver policies and procedure manuals.

c) Information regarding self-directed services is initially provided by the MCO during the service plan process, at which time the Participant Choice form is completed and signed by the participant, and the choice is indicated on the participant's service plan. This information is reviewed at least annually with the member. The option to end self-direction can be discussed, and the decision to choose agency-directed services can be made at any time.

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

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

- f. Participant Direction by a Representative.** Specify the state's policy concerning the direction of waiver services by a

representative (*select one*):

The state does not provide for the direction of waiver services by a representative.

The state provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: (*check each that applies*):

Waiver services may be directed by a legal representative of the participant.

Waiver services may be directed by a non-legal representative freely chosen by an adult participant.

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Waiver services may be directed by a non-legal representative of an adult waiver-eligible participant. An individual acting on behalf of the participant must be freely chosen by the participant. This includes situations when the representative has an activated durable power of attorney (DPOA). The DPOA process involves a written document in which participants authorize another individual to make decisions for them in the event that they cannot speak for themselves. A DPOA is usually activated for health care decisions. The extent of the non-legal representative's decision-making authority can include any or all of the responsibilities outlined in E-1-a that would fall to the participant if he/she chose to self-direct services. Typically, a durable power of attorney for health care decisions, if activated, cannot be the participant's paid attendant for Personal Services and/or Enhanced Care Services.

In the event that a non-legal representative has been chosen by an adult participant, the support team, along with the participant will identify the roles and responsibilities of the non-legal representative and these roles and responsibilities will be documented in the Person-Centered Service Plan. The designation of a representative must comport with state policy and procedures for mitigation of conflict of interest.

To ensure that non-legal representatives' function in the best interests of the participant, additional safeguards are in place. Quality of care is continuously monitored by the MCO. The MCO may discontinue the self-direct option and offer agency-directed services when, in the judgment of the MCO, as observed and documented in the participant's case file, certain situations arise, particularly when the participant's health and welfare needs are not being met. In addition, post-pay reviews completed by the fiscal agent and quality assurance reviews completed by the KDADS Regional Field Staff and/or MCO staff serve to monitor participant services and serve as safeguards to ensure the participant's best interests are followed. Any decision to restrict or remove a participant's opportunity to self-direct care, made by a KanCare MCO, is subject to the grievance and appeal protections detailed in Appendix F.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Enhanced Care Service		
Overnight Respite Care		
Personal Care Service (PCS)		
Financial Management Services (FMS)		

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

Yes. Financial Management Services are furnished through a third party entity. *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

Governmental entities

Private entities

No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

FMS are covered as the waiver service specified in Appendix C-1/C-3

The waiver service entitled:

Financial Management Services

FMS are provided as an administrative activity.

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Enrolled FMS providers will furnish Financial Management Services using the Agency with Choice provider model. The provider requirements will be published and placed on the Kansas Medical Assistance Program (KMAP) website and/or in the KanCare MCO provider manuals and websites.

Organizations interested in providing Financial Management Services (FMS) are required to contract with KDADS, or their designee. The contract must be signed prior to enrollment in KMAP to provide the service. The agreement identifies the waiver programs under which the organization is requesting to provide FMS and outlines general expectations and specific provider requirements. The agreement will be renewed annually, and approval is subject to satisfactory completion of the required GAAP audit. KanCare MCOs will not credential any application without a fully executed FMS Provider agreement.

For new organizations seeking to be a FMS provider, the FMS provider agreement and accompanying documentation are reviewed by the State Operating Agency and/or their designee to ensure that all assurances are satisfied as part of a readiness review prior to signing by the Secretary of KDADS, or designee.

All standards, certifications and licenses that are required for the specific field through which service is provided including: professional license / certification if required and adherence to KDADS' training and professional development requirements. All HCBS providers are required to pass background checks consistent with the KDADS' Background Check Policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have a prohibited offense, as listed in K.S.A. 39-2009, is not eligible for reimbursement of services under Medicaid funding.

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

FMS organizations are required to submit the following documents with the signed FMS provider agreement as a part of the readiness review:

- Community Developmental Disability Organization (CDDO) affiliate agreement (IDD only)
- Secretary of State Certificate of Corporate Good Standing
- W-9 form
- Proof of Liability Insurance
- Proof of Workers Compensation insurance
- Copy of the most recent quarterly operations report or estimate for first quarter operations
- Financial statements (last 3 months bank statements or documentation of line of credit)
- Copy of the organization's Policies and Procedures manual, to include information that covers requirements listed in the FMS Medicaid Provider Manual.
- Including process for conducting background checks
- Process for establishing and tracking workers wage with the participant

The FMS provider agreement and accompanying documentation are reviewed by the State Operating Agency and all assurances are satisfied prior to signing by the Secretary of KDADS (or designee).

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

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

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide (*check each that applies*):

Supports furnished when the participant is the employer of direct support workers:

Assist participant in verifying support worker citizenship status

Collect and process timesheets of support workers

Process payroll, withholding, filing and payment of applicable federal, state and local employment-

related taxes and insurance

Other

Specify:

Supports furnished when the participant exercises budget authority:

Maintain a separate account for each participant's participant-directed budget

Track and report participant funds, disbursements and the balance of participant funds

Process and pay invoices for goods and services approved in the service plan

Provide participant with periodic reports of expenditures and the status of the participant-directed budget

Other services and supports

Specify:

Additional functions/activities:

Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency

Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency

Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget

Other

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

a) The state verifies FMS providers meet waiver standards and state requirements to provide financial management services through a biennial review process. A standardized tool is utilized during the review process and the process includes assurance of provider requirements, developed with stakeholders and the State Medicaid Agency (Kansas Department of Health and Environment).

Requirements include agreements between the FMS provider and the participant, Direct Service Worker and the State Medicaid Agency and verification of processes to ensure the submission of Direct Service Worker time worked and payroll distribution.

Additionally, the state will assure FMS provider development and implementation of procedures including, but not limited to, procedures to maintain background checks; maintain internal quality assurance programs to monitor participant and Direct Service Worker satisfaction; maintain a grievance process for Direct Service Workers; and offer choice of Information and Assistance services.

The Division of Legislative Post Audit contracts with an independent accounting firm to complete Kansas' state wide single audit each year. The accounting firm must comply with all requirements contained in the single audit act. The Medicaid program, including all home and community-based services waivers, is a required component of every single state audit.

Independent audits of the waiver will look at cost-effectiveness, the quality of services, service access, and the substantiation of claims for HCBS payments. Each HCBS provider is to permit the KDADS, its designee, or any other governmental agency acting in its official capacity to examine any records and documents that are necessary to ascertain information pertinent to the determination of the proper amount of a payment due from the Medicaid program. The Surveillance and Utilization Review Unit of the fiscal agent completes the audits of both participants and providers (K.A.R. 30-5-59).

b) The Operating Agency is responsible for performing and monitoring the FMS review process. State staff will conduct the review and the results will be monitored by KDADS. A system for data collection, trending and remediation will be implemented to address individual provider issues and identify opportunities for systems change. The Kansas Department of Health and Environment through the fiscal agent maintains financial integrity by way of provider agreements signed by prospective providers during the enrollment process and contract monitoring activities.

c) All FMS providers are assessed on a biennial basis through the FMS review process and as deemed necessary by the State Medicaid Agency. d) State staff will share the results of state monitoring and auditing requirements, with the KanCare MCOs, and state/MCO staff will work together to address/remediate any issue identified. FMS providers also must contract with KanCare MCOs to support KanCare members and will be included in monitoring and reporting requirements in the comprehensive KanCare quality improvement strategy.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

Case Management Activity. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Waiver Service Coverage.

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Home and Environmental Modification Services (HEMS)	
Enhanced Care Service	
Wellness Monitoring	
Specialized Medical Care	
Specialized Medical Equipment and Supplies (SMES)	
Residential Supports	
Vehicle Modification Services (VMS)	
Overnight Respite Care	
Medical Alert Rental	
Personal Care Service (PCS)	
Children's Integrated Community Supports (CHICS)	
Financial Management Services (FMS)	
Supported Employment (SE)	
Day Supports	

Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

No. Arrangements have not been made for independent advocacy.

Yes. Independent advocacy is available to participants who direct their services.

Describe the nature of this independent advocacy and how participants may access this advocacy:

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

The Disability Rights Center (DRC) is another agency that can assist participants on the waiver to access advocacy. The Disability Rights Center of Kansas (DRC), is a public interest legal advocacy agency empowered by federal law to advocate for the civil and legal rights of Kansans with disabilities.

Kansas Centers for Independent Living (CILs) also offer advocacy assistance for people with disabilities as one of their five core services that are grant funded.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

I. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

One of the participant's opportunities as well as responsibilities is the ability to discontinue the self-direct option. If the participant chooses to discontinue the self-direct option, he/she is to;

*Notify all providers as well as the Financial Management Services (FMS) entity. The participant is to maintain continuous PCS, ECS and/or Overnight Respite coverage, whichever service was previously documented on the participant's Service Plan, with the authorization for service;

*Give a thirty (30) day notice of their decision to the Community Developmental Disability Organization (CDDO), the targeted case manager, and the MCO to allow for the coordination of service provision.

The duties of CDDO staff are to:

*Present the participant with the other service options and the providers of those services in the CDDO area, completing a choice form.

The duties of the consumer's case manager and the KanCare MCO in collaboration, are to:

- Explore other service options and receive a copy of the completed new Choice form from the CDDO; and
- Advocate for participants by arranging for services with individuals, businesses, and agencies for the best available service within limited resources.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

The participant's chosen MCO may discontinue self-direction and offer agency-directed services when, in the MCO's professional judgment as observed and documented in the participant's case file, one or more of the following occurs:

1. if the participant/representative does not fulfill the responsibilities and functions required;
2. if the health and welfare needs of the participant are not being met based on documented observations of the MCO and KDADS Quality Assurance staff, or confirmation by APS, and all training methods for the participant have been exhausted;
3. if the direct support worker has not adequately performed the services as outlined in the Peron-Centered Service Plan (Service Plan);
4. if the direct support worker has not adequately performed the necessary tasks and procedures; or
5. if the participant/representative or service provider has abused or misused self-direction including:
 - the participant/representative has directed the direct support worker to provide, and the direct support worker has in fact provided, paid attendant care services beyond the scope of the needs assessment and/or POC;
 - the participant/representative has directed the service providers to provide, and the service providers has in fact provided paid comprehensive support or Enhanced Care Services beyond the scope of the service definition;
 - the participant/representative has submitted signed time sheets for services beyond the scope of the needs assessment and/or the Service Plan;
 - the participant/representative has continually directed the direct support worker to provide care and services beyond the limitations of their training, or the training of the service providers for health maintenance activities in a manner that has a continuing adverse effect on the health and welfare of the participant.

The following warrant termination of the self-directed care option without the requirement to document an attempt to remedy:

1. the participant/representative has falsified records that result in claims for services not rendered;
2. the participant has Health Maintenance Activities or medication setup and the participants attending physician or RN no longer authorizes the participant to self-direct his/her care; or
3. the participant/representative has committed a fraudulent act.

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

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

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1	2871	
Year 2	2871	
Year 3	2871	
Year 4	2871	
Year 5	2871	

Appendix E: Participant Direction of Services

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

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both:*

Participant/Co-Employer. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

Participant/Common Law Employer. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

Recruit staff

Refer staff to agency for hiring (co-employer)

Select staff from worker registry

Hire staff common law employer

Verify staff qualifications

Obtain criminal history and/or background investigation of staff

Specify how the costs of such investigations are compensated:

The direct service worker (provider) will assume the cost of criminal history and/or background investigations conducted by the financial management service provider as an administrative function.

Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

All HCBS providers are required to pass background checks consistent with the KDADS' Background Check policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have been substantiated for a prohibited offense as listed in K.S.A. 39-2009 is not eligible for reimbursement of services under Medicaid funding.

Determine staff duties consistent with the service specifications in Appendix C-1/C-3.

Determine staff wages and benefits subject to state limits

Schedule staff

- Orient and instruct staff in duties
 - Supervise staff
 - Evaluate staff performance
 - Verify time worked by staff and approve time sheets
 - Discharge staff (common law employer)
 - Discharge staff from providing services (co-employer)
 - Other
- Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

- Reallocate funds among services included in the budget
 - Determine the amount paid for services within the state's established limits
 - Substitute service providers
 - Schedule the provision of services
 - Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3
 - Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3
 - Identify service providers and refer for provider enrollment
 - Authorize payment for waiver goods and services
 - Review and approve provider invoices for services rendered
 - Other
- Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

ii. **Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iii. **Informing Participant of Budget Amount.** Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iv. **Participant Exercise of Budget Flexibility.** *Select one:*

Modifications to the participant directed budget must be preceded by a change in the service plan.

The participant has the authority to modify the services included in the participant directed budget without prior approval.

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

--

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

(a) Pursuant to 42 CFR § 431.210, individuals applying for or renewing Medicaid eligibility may request a fair hearing following an adverse eligibility determination. The state provides individuals with two opportunities to challenge an eligibility determination. The state's HCBS financial eligibility determination can be challenged in a fair hearing. The state's HCBS functional assessment eligibility determination can also be challenged in a fair hearing. Individuals are notified of their fair hearing rights in a notice of action that is sent by the State following an adverse financial eligibility decision and following an adverse functional eligibility decision. See additional explanation below regarding the functional assessment eligibility decision.

(b) Pursuant to 42 CFR § 438.404, individuals denied a covered service or provider of their choice by an MCO may challenge the denial in a fair hearing. Individuals are notified of their MCO appeal rights and fair hearing rights in a notice of adverse benefit determination and notice of appeal resolution sent by the MCO. See additional explanation below.

(c) Pursuant to 42 CFR § 438.404, individuals whose covered services are suspended, reduced or terminated by an MCO may challenge the suspension, reduction or termination in a fair hearing. Individuals are notified of their MCO appeal rights and their fair hearing rights in a notice of adverse benefit determination and notice of appeal resolution sent by the MCO. See additional explanation below.

ELIGIBILITY DECISIONS INVOLVING FUNCTIONAL ASSESSMENTS

As the single state Medicaid agency, KDHE has delegated the functional assessment process to the Kansas Department for Aging and Disability Services (KDADS). KDADS has contracted with independent assessors to conduct level of care (LOC) functional assessments. The independent assessor contractor conducts participant waiver assessments for current and potential participants. Each KDADS' Waiver Program Manager reviews each initial eligibility packet for LOC evaluation and determines waiver program functional eligibility before KDHE determines financial eligibility. Initial functional LOC assessments that result in a "not eligible" determination may be challenged in a fair hearing. In addition, any reassessment that results in a change from eligible to not eligible may be challenged in a fair hearing.

Notices of Action for Eligibility Decisions:

The State is responsible for notifying an individual of an adverse action if an application for medical assistance (choice of HCBS vs. institutional services) is denied. The State issues a notice of action following an adverse financial decision or adverse functional assessment that notes whether the participant met or did not meet eligibility criteria for an HCBS waiver. The notice includes the right to challenge the adverse decision in a fair hearing and the procedures for submitting a request for a fair hearing. The State's notice does not include a requirement to request a grievance prior to requesting a fair hearing.

Fair Hearings for Eligibility Decisions:

If an individual is not satisfied with the decision made about eligibility, the individual or individual's representative may ask for a fair hearing. Pursuant to the Kansas Administrative Procedures Act, K.S.A. 77-501, et seq., the State provides participants with a fair hearing administered by the Kansas Office of Administrative Hearings (OAH). OAH assigns a Presiding Officer to each hearing request. The Presiding Officer will listen to the facts, hear motions, conduct the hearing, and make a decision based on the relevant facts and law within the authority granted to an administrative law judge. The request for a hearing must be received within 33 days of the date of the notice of action. Fair hearings may be requested verbally by calling 1-800-888-8888 or in writing. Written requests should be mailed or faxed to:

Kansas Office of Administrative Hearings
1020 S. Kansas Ave. Topeka, KS 66612-1327 Fax: 785-296-4848

MCO DECISIONS INVOLVING HOME AND COMMUNITY BASED SERVICES

KDHE has contracted with three KanCare managed care organizations (MCOs) to manage the medical assistance of nearly all its Medicaid participants. KDHE requires the MCOs to develop grievance and appeal processes that are consistent with federal and state regulations and Attachment D of the State's contract with CMS. The grievance and appeal processes must include state fair hearings, expedited appeals, and expedited state fair hearings. Each enrolled participant is provided information about grievances, appeals and fair hearings in their KanCare participant enrollment packet and in each MCO's Participant Handbook. The MCOs' grievance, appeal and fair hearing processes can also be found at the KanCare website.

Notices of Adverse Benefit Determination by MCOs:

KDHE requires the MCOs to issue a notice of an adverse benefit determination for each adverse decision that meets the definition of an adverse benefit determination in 42 CFR § 438.400. The notice informs the participant of the right to challenge the adverse decision by submitting an appeal to their assigned MCO. The notice includes the requirement for the participant to complete the MCO's appeal process prior to submitting a request for a fair hearing and the procedures for submitting a request for an appeal and fair hearing. The MCO's notice does not include a requirement to request a grievance prior to requesting a fair hearing.

MCO Appeals:

KDHE requires the MCOs to develop a participant appeal system that allows participants to submit an appeal to their assigned MCO following an adverse benefit determination made by the MCO pursuant to 42 CFR § 438.402. The adverse decision must meet the definition of an adverse benefit determination in 42 CFR § 438.400 to qualify for an appeal. An adverse benefit determination is defined as the denial of services or a limitation of services, including the type of service; the reduction, suspension, or termination of a service the participant has been receiving; the denial, in whole or part, of payment for a service; or the failure of the health plan to act within established time requirements for service accessibility; the failure of an MCO to resolve grievances and appeals as required by 42 CFR § 438.408; and the denial of a participant's request to dispute a financial liability. An appeal is a request for the MCO to review its adverse benefit determination. Participants or a friend, an attorney, or anyone else on the participant's behalf can submit an appeal verbally or in writing to the MCO. The Customer Service staff for each MCO can also help the participant submit an appeal. An MCO appeal must be submitted within 63 days calendar days of the date on the MCO's notice of adverse benefit determination. The MCOs are required to resolve appeals within 30 calendar days of receipt unless more time is needed. The participant will be notified if the MCOs require more than 30 days to resolve the appeal. If the resolution time period is extended, the member's appeal must be resolved within 44 calendar days. If the member receives waiver services, previously authorized waiver services will be continued during the MCO appeal time period in order to ensure that continuity of care is provided while the appeal period is in effect and to provide the member time to appeal. The MCOs acknowledge, process and issue responses to all appeals submitted by a participant. The MCO staff logs and tracks all appeals. KDHE and KDADS have access to this information at any time.

Fair Hearings for MCO Decisions:

If an individual is not satisfied with the MCO's decision following an appeal review, the participant or participant's representative may ask for a fair hearing. Pursuant to the Kansas Administrative Procedures Act, K.S.A. 77-501, et seq., the State provides participants with a fair hearing administered by the Kansas Office of Administrative Hearings (OAH). OAH will assign a Presiding Officer to each hearing request. The Presiding Officer will listen to the facts, hear motions, conduct the hearing, and make a decision based on the relevant facts and law within the authority granted to a Presiding Officer. The request for a hearing must be received within 123 days of the date of the notice of appeal resolution. Fair hearings may be requested verbally by calling the Customer Service telephone numbers at each MCO. Written requests should be mailed to the MCO or to the Office of Administrative Hearings at:

Kansas Office of Administrative Hearings
1020 S. Kansas Ave., Topeka, KS 66612-1327
Fax: 785-296-4848

FEE-FOR-SERVICE DECISIONS INVOLVING MEDICAL SERVICES

Participants who are not part of the KanCare program are part of the State's fee-for-service (FFS) Medicaid program. Tribal members have the option of opting out of KDHE's managed care Medicaid program. If a tribal member chooses to opt out, the member will become a participant in KDHE's FFS Medicaid program. FFS participants have the right to challenge a denial, suspension, reduction or termination of FFS medical services by KDHE. As the single state Medicaid agency, KDHE has delegated the administration of its FFS program to its contracted fiscal agent. KDHE requires the fiscal agent to operate the participant FFS state fair hearing system consistent with federal and state regulatory requirements. The fiscal agent staff logs and tracks all FFS state fair hearings. KDHE and KDADS have access to this information at any time. The fiscal agent informs FFS participants that lodging a complaint and/or grievance is not a prerequisite or substitute for a fair hearing and is a separate activity from a fair hearing in its FFS Enrollment Booklet and notice of action.

Notices of Action for FFS Medical Service Decisions:

KDHE requires the fiscal agent to notify an FFS participant of an adverse action in the event that the request for a medical service is denied, suspended, reduced or terminated. The fiscal agent issues a notice of action following the adverse decision. The notice includes the right to challenge the adverse decision in a fair hearing and the procedures for submitting a request for a fair hearing. The fiscal agent's notice does not include a requirement to request a grievance prior to requesting a fair hearing.

Fair Hearings for FFS Decisions:

If an FFS participant is not satisfied with the decision made about FFS medical services, the participant or participant's representative may ask for a fair hearing. Pursuant to the Kansas Administrative Procedures Act, K.S.A. 77-501, et seq., the State provides FFS participants with a fair hearing administered by the Kansas Office of Administrative Hearings (OAH). OAH assigns a Presiding Officer to each hearing request. The Presiding Officer will listen to the facts, hear motions, conduct the hearing, and make a decision based on the relevant facts and law within the authority granted to an administrative law judge. The request for a hearing must be received within 33 days of the date of the notice of action. Fair hearings may be requested verbally by calling 1-800-766-9012 or in writing. Written requests should be mailed or faxed to:

Kansas Office of Administrative Hearings
1020 S. Kansas Ave., Topeka, KS 66612-1327 Fax: 785-296-4848

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

No. This Appendix does not apply

Yes. The state operates an additional dispute resolution process

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

No. This Appendix does not apply

Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

Under the KanCare program, nearly all Medicaid services, including nearly all HCBS waiver services, will be provided through one of the three managed care organizations (MCO). The MCOs are contracted with the single state Medicaid agency, the Kansas Department of Health and Environment (KDHE). KDHE requires the MCOs to develop a participant grievance and appeal system consistent with federal regulations and Attachment D of the State's contract with CMS. Participants have the right to submit grievances to their assigned MCO at any time. A description of how KanCare participants are informed that filing a grievance is not a prerequisite for a fair hearing is included at Appendix F.1. KanCare participants are informed that filing an appeal with the MCO is a prerequisite for a fair hearing in the MCOs' notice of adverse benefit determination. The MCOs acknowledge, process and issue responses to all grievances submitted by a participant to their assigned MCO. The MCO staff logs and tracks all grievances. KDHE and KDADS have access to this information at any time.

Participants who are not part of the KanCare program are part of the State's fee-for-service (FFS) Medicaid program. As the single state Medicaid agency, KDHE has delegated the administration of its FFS program to its contracted fiscal agent. KDHE requires the fiscal agent to operate the participant FFS grievance system consistent with state regulatory requirements. FFS participants have the right to submit grievances to the State's fiscal agent at any time. The fiscal agent staff logs and tracks all FFS grievances. KDHE and KDADS have access to this information at any time. The fiscal agent informs FFS participants that lodging a complaint and/or grievance is not a prerequisite or substitute for a fair hearing and is a separate activity from a fair hearing in its FFS Enrollment Booklet and notice of action

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Eligibility Grievances: Applicants and participants have the right to submit a grievance to KDHE about any matter related to the eligibility process. A grievance is defined as any expression of dissatisfaction about any matter other than an adverse eligibility decision. Grievances can be filed in writing or verbally. An applicant or participant may submit an eligibility grievance to KDHE at any time. The KanCare eligibility staff log all grievances submitted by applicants, participants, or their representatives. KDHE researches each grievance, resolves it, and a telephone or written resolution response is provided within 30 days of receipt. Current eligibility grievance categories include CHIP premiums, customer service, eligibility determination, timeliness, and customer self-service portal.

MCO Grievances: KanCare participants have the right to submit a grievance to their assigned MCO at any time. A grievance is defined as any expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances can be submitted in writing or verbally. The MCOs acknowledge each grievance in writing within 10 calendar days of receipt. The MCOs issue a written resolution response to the participant within 30 calendar days of receipt (except in cases where it is in the best interest of the participant that the resolution timeframe be extended by 14 days). If the MCO fails to send a grievance resolution response within the required timeframe, the participant is deemed to have exhausted the MCO's grievance process, and the participant may initiate a state fair hearing. The MCO staff logs and tracks all grievances. Current MCO grievance categories include CMS' MCPAR report's grievance categories, as well as additional NEMT categories (13 total NEMT categories) added by KDHE. KDHE and KDADS have access to this information at any time.

FFS Grievances: FFS participants have the right to submit a grievance to KDHE's fiscal agent about any matter involving a FFS medical service at any time. A grievance is defined as any expression of dissatisfaction about any matter, including an adverse FFS medical service decision. A participant may submit a grievance verbally or in writing. The fiscal agent staff logs all grievances submitted by FFS participants. The fiscal agent researches, resolves and issues a response to all grievances by telephone or in writing within 30 calendar days. FFS grievance categories are identical to the grievance categories identified in the MCPAR, as well as the additional NEMT categories added to those categories by KDHE. The fiscal agent provides all FFS participants with an FFS enrollment guide. The enrollment guide informs participants that lodging a complaint and/or grievance is not a prerequisite or substitute for a fair hearing and is a separate activity from a fair hearing. KDHE and KDADS have access to this information at any time.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program. *Select one:*

Yes. The state operates a Critical Event or Incident Reporting and Management Process (*complete Items b through e*)

No. This Appendix does not apply (*do not complete Items b through e*)

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

KDADS defined “adverse incidents” include the following: Death, Elopement, Emergency Medical Care, Law Enforcement Involvement, Misuse of Medications, Natural Disaster, Abuse, Neglect, Exploitation, Serious Injury, Suicide, Suicide Attempt, and use of Restraints, Seclusion, and Restrictive interventions.

The reporting process is almost identical for children and adults as the Department for Children and Families is responsible for all investigations of abuse, neglect, and exploitation in the State of Kansas. Below is a summary of that process.

Identification of the individuals/entities that must report critical events and incidents:

The Kansas statutes K.S.A. 39-1431 and K.S.A. 38-2223 identify mandated reporters required to report suspected Abuse Neglect, and Exploitation or Fiduciary Abuse of an adult or minor immediately to either Kansas Department for Children and Families or Law Enforcement. According to K.S.A. 39-1431, mandated reporters include: (a) Any person who is licensed to practice any branch of the healing arts, a licensed psychologist, a licensed master level psychologist, a licensed clinical psychotherapist, the chief administrative officer of a medical care facility, a teacher, a licensed social worker, a licensed professional nurse, a licensed practical nurse, a licensed dentist, a licensed marriage and family therapist, a licensed clinical marriage and family therapist, licensed professional counselor, licensed clinical professional counselor, registered alcohol and drug abuse counselor, a law enforcement officer, a case manager, a rehabilitation counselor, a bank trust officer or any other officers of financial institutions, a legal representative, a governmental assistance provider, an owner or operator of a residential care facility, an independent living counselor and the chief administrative officer of a licensed home health agency, the chief administrative officer of an adult family home and the chief administrative officer of a provider of community services and affiliates thereof operated or funded by the Kansas Department for Children and Families or licensed under K.S.A. 75-3307b and amendments thereto who has reasonable cause to believe that an adult or child is being or has been abused, neglected or exploited or is in need of protective services shall report, immediately from receipt of the information, such information or cause a report of such information to be made in any reasonable manner. An employee of a domestic violence center shall not be required to report information or cause a report of information to be made under this subsection.

Specifically, mandated reporters include but are not limited to: Staff working for any KDADS licensed or contacted organization, including Community Developmental Disability Organization (CDDO)s, the Aging and Disability Resource Center (ADRC), Financial Management Services Providers (FMS), Community Mental Health Centers (CMHC), Psychiatric Residential Treatment Facilities (PRTF) and Substance Abuse Treatment Facilities. All other individuals who may witness a reportable event may voluntarily report it.

The timeframes within which critical incidents must be reported: KSA 39-1431 requires other state agencies receiving reports that are to be referred to the Kansas DCF and the appropriate law enforcement agency, shall submit the report to the department and agency within six hours, during normal work days, of receiving the information. Outside of working hours, the reports shall be submitted to DCF on the first working day that the Kansas Department for Children and Families is in operation after the receipt of such information.

AIR is used to report adverse/critical incidents involving individuals receiving services by providers who are licensed by or contracted with KDADS including all HCBS waivers.

AIR reports are required to be submitted to KDADS w/in 24 hours of the individual becoming aware of the adverse incident. MCOs and their providers are all required to submit AIR reports. MCOs are required to follow-up with KDADS on all substantiated ANE reports. All AIR reports are required to be submitted by direct entry into the KDADS web-based AIR system.

- c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The participant's chosen KanCare MCO provides information and resources to all participants and caregivers regarding strategies to identify, prevent, report, and correct any instances of potential Abuse, Neglect, Exploitation or Fiduciary Abuse. Information and training on these subjects is provided by the MCOs to participants in the participant handbook, is available for review at any time on the MCO participant website, and website and is reviewed with each participant by the care management staff responsible for service plan development, and during the annual process of person-centered service plan development.

Depending upon the individual needs of each participant, additional training or information is made available and related needs are addressed in the participant's Person-Centered Service Plan. The information provided by the MCOs is consistent with the state's Abuse, Neglect, Exploitation and Fiduciary Abuse incident reporting and management process (although the MCOs also have additional incident management information and processes beyond those regarding reporting/management of participant Abuse, Neglect, Exploitation and Fiduciary Abuse).

CDDOs have a regulatory role for educating on, reporting of, and correcting events of Abuse, Neglect and Exploitation, as per K.A.R. 30-64-27. IDD waiver providers also have a regulatory responsibility for education on, reporting, and correcting abuse, neglect and exploitation, as per K.A.R. 30-63-28. K.A.R. 30-63-28(c) requires providers to "regularly conduct training and take other steps to ensure that any agent, person, parent, guardian, and any other individual from each person's support network is advised about how to contact the appropriate state agency charged with providing adult protective services whenever abuse, neglect, or exploitation is suspected or witnessed."

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

KDADS is the entity responsible for evaluating all adverse incident reports in accordance with KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110 and KDADS HCBS Adverse Incident Monitoring SOP. All events reported to AIRS are reviewed by KDADS staff to determine whether or not they meet the SOP definition of an adverse incident. Those that do not are screened out from further investigation by KDADS. Those that meet the definition are investigated by KDADS and contracted MCOs. Any event reported through AIRS that involves the possible abuse, neglect, exploitation or fiduciary abuse of children that was not reported first to DCF is immediately reported to DCF by KDADS for further investigation.

In accordance with the KDADS HCBS Adverse Incidents Monitoring Standard Operating Procedure (SOP), KDADS Program Integrity and Compliance Specialists (PICS) or their designated back-up(s) are responsible for checking AIRS for any newly reported adverse incident. AIRS will automatically distribute adverse incident reports for review based on the issue, KDADS provider/program type (e.g., Behavioral Health, Older Americans Act, Senior Care Act, HCBS Waiver), and county location of the incident. If data was entered incorrectly, the KDADS PICS must correct any errors, and re-route the review to the appropriate KDADS party. This process will occur within one business day of receipt of an adverse incident report.

If AIRS does not auto assign the adverse incident, the KDADS PICS will review the adverse incident report and assign it appropriately within AIR. If the member requires protective services intervention or review, the PICS will immediately notify and forward the adverse incident report to (DCF) for further investigation.

If an Adverse Incident was reported directly to DCF, DCF must adhere to the timeframes for incident review as defined in each of the HCBS waivers. DCF must notify KDADS outlining DCF's determination for the incident within five business days of the date of DCF determination, in accordance with the DCF Policy and Procedure Manual (Chapter 10320) and as defined in KSA 39-1433/38-2226.

For all submitted AIR reports, PICS first review AIRS adverse incident report information to determine if there is any indication of criminal activity and report any instances to law enforcement. If it is determined that there is suspected for Abuse, Neglect, Exploitation or Fiduciary Abuse, the KDADS PICS report immediately to DCF. Any areas of vulnerability would be identified for Additional training and assurance of education. PICS determine if the adverse incident report is screened in, screened out, or requires additional follow-up. Even for those incidents referred to DCF, PICS document the incident and notify the participant's MCO of the incident.

Within one business day of receiving an AIR report, KDADS PICS will determine the level of severity for each screened in adverse incident reported in AIRS, and will assign a level of severity. Within one business day of a determination of the severity level PICS will notify the participant's MCO and discuss further required investigation, follow-up, and corrective action planning as applicable. In the event the incident requires further discussion within KDADS or with MCOs, the PICS will notify the appropriate Program Manager and then notify the MCO to schedule a meeting and discuss. All use of restraint, seclusion or restrictive interventions shall be reviewed by the MCO to ensure adherence to policy and appropriate follow-up in accordance with the KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110. MCOs will review the report, investigate the incident (as appropriate), and identify the actions taken by the MCO to conclude the investigation. MCO actions are documented within AIRS.

KDADS Program Integrity and Compliance Specialists will review all MCO summary findings for all incidents involving restraints, seclusion and/or restrictive intervention to determine appropriate use in accordance with the Member's Person-Centered Service Plan. Corrective action plan (CAP) development, implementation and monitoring will comply with the KDADS HCBS Adverse Incidents Monitoring SOP. All use of restraint, seclusion or restrictive interventions shall be reviewed by the MCO to ensure adherence to policy and appropriate follow-up.

- The timeframes for investigating and completing an investigation:

Following the DCF Prevention and Protective Services (PPS) Policy and Procedure Manual

(<http://content.dcf.ks.gov/PPS/robohelp/PPMGenerate/>) the Kansas Protection Report Center (KPRC) completes an initial assessment on all reports received to determine whether criteria is met to assign the report for further assessment. DCF assigns the response time, ranging from same day to 7 days, depending on whether abuse is suspected and other characteristics. PPS is required to make a case finding in 30 working days from case assignment, unless allowable reasons exist to delay the case finding decision.

All adverse incidents must be reported in AIRS no later than 24 hours of a mandated reported becoming aware of the incident as described in the KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110. KDADS assigns the report to the participant's managed care organization within one business day of receiving the report. The managed care organization has 30 days to complete all necessary follow-up measures and return to KDADS for confirmation and final resolution.

- The entity that is responsible for conducting investigations and how investigations are conducted:

DCF is responsible for contacting the involved child or adult, alleged perpetrator and all other collaterals to obtain relevant information for investigation purposes.

Review and Follow-up for Abuse, Neglect, Exploitation, and Fiduciary Abuse investigation and follow-up in accordance

with K.S.A. 39-1433 for adults, K.S.A. 38-2226 for children.

1. DCF is statutorily responsible for all Abuse, Neglect, Exploitation, and Fiduciary Abuse investigation and follow-up in accordance with K.S.A. 39-1433 for adults, K.S.A. 38-2226 for children, and DCF Prevention and Protection Services (PPS) Policy and Procedure Manual. KSA 39-1433 also includes: duties of Kansas department for children and families; face-to-face visit; investigation and evaluation; findings referred to appropriate regulating authority, when; information provided to certain persons. (39-1433 (ksrevisor.org))

DCF reportable event reports that come through AIRS will be reviewed by KDADS and referred to DCF, if the report indicates possible Abuse, Neglect, Exploitation, or Fiduciary Abuse of adults or children and requires protective services.

2. DCF will determine if the reportable event will be handled by Adult Protective Services (APS) or Child Protective Services (CPS). The investigation will conclude with an investigation status report that is sent to KDADS.
3. The report will not be assigned for further assessment or may be screened out after acceptance if the following apply:
 - a. The report does not meet the criteria for further assessment per DCF PPS Policy and Procedure Manual;
 - b. The event has previously been investigated;
 - c. DCF does not have the statutory authority to investigate;
 - d. Unable to locate family.
4. Not all reportable events require remediation; DCF shall determine which reportable events will result in remediation.

The process and timeframes for informing the participant (or the participant's family or legal representative as appropriate) and other relevant parties (e.g., the waiver providers, licensing and regulatory authorities, the waiver operating agency) of the investigation results includes:

Notice of Department Finding per DCF PPS Policy Number 2540:

The Notice of Department Finding for reports is PPS 2012. The Notice of Department Finding informs pertinent persons who have a need to know of the outcome of an investigation of child Abuse/Neglect. The Notice of Department Finding also provides information regarding the appeal process.

All case decisions/findings shall be staffed with the CPS Supervisor/designee and a finding shall be made within thirty (30) working days of receiving the report. DCF sends the Notice of Department Finding to relevant persons who have a need to know of the outcome of an investigation of child abuse/neglect on the same day, or the next business day, of the case finding decision.

KDADS has primary responsibility for ensuring that all adverse incidents are reviewed and addressed in accordance with KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110 and KDADS Adverse Incident Monitoring SOP. Review and follow-up for all other adverse incidents shall be completed by KDADS or the MCO, depending on assigned level of severity.

KDADS first reviews the adverse incident report information to determine if there is any indication of criminal activity or ANE that has not been reported to appropriate agencies. If the incident has not already been reported to DCF, KDADS reports it to DCF. KDADS next determines if the incident is screened in, screened out, or requires follow-up. For all screened in adverse incidents, KDADS staff assign a severity level. MCOs take steps for follow-up with providers/members and resolve the incident or implement remediation steps. KDADS tracks and approves MCO investigation and resolution steps. KDADS staff review MCO follow-up and resolution details. KDADS also determines if the incident should require a corrective action plan (CAP) outlining the deficiencies and necessary steps to resolve. KDADS monitors MCO CAP remediation efforts and required completion dates to ensure timely resolution.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

KDADS is the entity responsible for overseeing the operation of the incidence management system called Adverse Incidence Reporting (AIR) system. Kansas Department for Children and Families, Division of Adult Protective Services is responsible for overseeing the reporting of and response to all critical incidents and events related to abuse, neglect and exploitation. Adult Protective Services maintains a data base of all critical incidents/events and makes available the contents of the data base to the Kansas Department for Aging and Disability Services and the Kansas Department of Health and Environment, single state Medicaid agency, on an on-going basis.

The KDADS Quality Program Manager is responsible for reviewing the incidences reported to AIR and assigning incident to appropriate KDADS field staff for discovery, follow up and remediation. The Quality Program Manager and the DCF Adult Protective Services Program Manager gather, trend and evaluate data from both sources and report the data to KDADS CSP Director and the State Medicaid Agency."

"The KDADS quality team is responsible for reviewing reported critical incidents and events. The data is collected and compiled, trended by waiver population so that it can be analyzed to enable the identification of trends/patterns and the development of quality improvement/ remediation strategies to reduce future occurrence of critical incidents or events. This information will also be a monitoring, reporting and follow up element of the comprehensive KanCare quality improvement strategy, managed the KanCare QI Strategy process to support overall quality improvement activities for the KanCare program."

KDADS conducts reviews on a quarterly basis to educate and assess the participant's knowledge and ability and freedom to prevent or report information about Abuse, Neglect, and Exploitation. If it is determined that there is suspected for Abuse, Neglect or Exploitation, the KDADS Field Staff report immediately. Any areas of vulnerability would be identified for additional training and assurance of education."

MCOs are granted access to the Adverse Incident Reporting (AIR) system. Critical events or incidents submitted to the AIR systems are available to MCOs as part of KDADS notification to the MCOs a critical event had occurred. KDADS quality team has primary responsibility for ensuring the incidents are reviewed and addressed. KDADS quality team will reach out to the MCOs when collaboration and joint effort in follow up is necessary in order to effectively remediate an event or incident. Currently, DCF shares all APS determinations (Screened Out, Unsubstantiated and Substantiated) and Child Protective Services (CPS) provides intakes and screen-outs via the Community Support Services Protection Report Center (CSSPRC) mailbox. The reports received from DCF to the CSSPRC mailbox will be manually entered into the AIR system until the auto feed between DCF and AIR goes live. KDADS Program Integrity Staff monitor assigned counties and forward Substantiated reports to the corresponding waiver program manager, MCO Program Integrity/Quality Staff. Once the auto feed is complete all DCF reports will automatically be entered into AIR and Abuse, Neglect and Exploitation will only need to be reported to DCF. All DCF reports entered into AIR either manually or by auto feed will go through the same process as all other adverse incidents (verify info, assign to correct MCO for follow-up/remediation, and final review/remediation is done by KDADS). The AIR system will allow for all necessary parties to be notified.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

The state does not permit or prohibits the use of restraints

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The use of restraints is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- Identify the types of restraints permitted:

The IDD waiver allows for the authorized use of personal (physical holds), mechanical, and chemical restraint. Under K.S.A. 39-1401 Abuse, Neglect, or Exploitation of residents, the following are not permitted:

- 1.unreasonable use of physical restraint or medication that harms or is likely to harm a resident;
- 2.unreasonable use of a physical or chemical restraint or medication as punishment, for convenience, in conflict with a physician's orders or as a substitute for treatment except where such conduct or physical restraint is in furtherance of the health and safety of the resident or another resident.

- Alternative methods to avoid the use of restraints:

Participants served shall have the right to be free from the unauthorized, unsafe, or unwarranted use of restraint. Restraint is prohibited for the purposes of discipline, punishment or staff member convenience. The use of restraint is not a treatment intervention, and restraint is prohibited as an alternative to providing adequate levels of staff to manage the participant. A waiver participant and his/her designated legal representatives, guardians, and any informal supports or service providers requested by the participant, will participate in an annual (at a minimum) Person-Centered Service Plan meeting with the participant's MCO care coordinator to develop a Person-Centered Service Plan. The MCO care coordinator will ensure that the participant and his/her legal guardian and representatives develop strategies to address participant's preferences that put him/her at a health or safety risk. These strategies will only be to mitigate risks to the health and safety of the participant and other individuals whom might be harmed by a dangerous act by the participant. These strategies will include the use of positive behavioral supports, other less restrictive interventions, and a clear understanding will be conveyed that the use of restraint is a measure of last resort to protect the safety and health of the participant, his/her guardians, providers and informal supports. When situations arise that require behavioral intervention for a participant, methods of de-escalation, justification for authorized restraint use and the method of restraint applied must be documented by the involved staff.

All providers shall facilitate efforts to define alternative methods of behavior management to keep a potential safety situation from escalating to emergency status. These positive behavior supports may include, but are not limited to, restructuring the environment, reducing exposure to negative stimuli, positive redirection, changing instructions, providing visual supports to facilitate understanding.

To avoid use of restraints, KDADS reviews provider policies, procedures, training & documentation for evidence that all potentially effective less restrictive alternatives were tried & proven ineffective. KDADS conducts reviews to identify evidence of informed consent that includes information about positive behavior programming, environmental modifications and accommodations and services available from the provider. Informed consent must also include a complete review of the risks, benefits and side effects prior to any restraints and/or seclusion including psychotropic medications, and that the required initial and ongoing assessment and responsive modifications are completed.

- Methods for detecting the unauthorized use of restraints:

Each incident of restraint will be entered into AIRS for use in identifying unauthorized use of restraints. KDADS staff monitors each use of restraint and conducts analysis to determine unauthorized use and contacts the participant's Managed Care Organization (MCO) to discuss any potential unauthorized use. This information will be used by KDADS to identify and address any negative trends in the use of restraint if the situation warrants intervention and remediation. Additionally, the Community Developmental Disability Organization monitors for compliance with regulatory standards and statute to assure protection from unauthorized restraint/seclusion.

The MCO care coordinator will conduct a review within 30 calendar days of implementation of the PCSP to determine the effectiveness of defined interventions and to discuss if adjustments to the restrictive interventions plan should be made with the input of the participant's designated team members to include parent/legal guardian and care coordinator. A team meeting may be convened at any time to review and possibly make changes in the use of restrictive interventions, including restraint. Any plan developed by the

team shall be signed by the participant's parent/legal guardian to document his/her approval. No plan shall be implemented without the participant's parent/legal guardian's consent. Following this initial review, on-going review of use of restrictive interventions, including restraint, will be part of the PSCP review annually or more often as deemed necessary by the designated team members.

- The protocols that must be followed when restraints are employed (including the circumstances when their use is permitted) and how their use is authorized:

When restraint is used, according to plan or emergency and as soon as possible after, the immediate staff and, if available, witnessing staff will document the use of the restraint as described in the required documentation section below. From on-set of behavior to discontinuation of the restraint, the staff reflect on and document the Support Plan strategies they would implement again, or they would use differently. Staff shall notify the care coordinator and the parent/legal guardian, as identified in the Support Plan.

Physical restraint techniques should only be used when all less restrictive methods of intervening have been exhausted and are limited to situations in which there is serious, probable and imminent threat of bodily harm to self or others by a person with the present ability to cause such harm. Physical restraints are not allowed for the sole purpose of mediating destruction of property and must never be used as a punitive form of discipline or as a threat to control or gain compliance of a person's behavior. In all situations less restrictive alternatives including, but not limited to, positive behavior supports, constructive, non-physical de-escalation and re-structuring of the environment shall be considered prior to initiating a physical restraint, and all such use will be compliant with Article 63 – Developmental Disabilities – Licensing Providers of Community Services.

- The practices that must be employed to ensure the health and safety of individuals:

- 1.If a participant is known to have any medical condition such that restraint might endanger his/her health and safety, use of restraint is prohibited.
- 2.Restraint shall be administered only when needed to ensure the safety of the participant and/or other individuals in the immediate environment, (including staff members, other participants, other individuals) and only when needed to prevent the continuation or renewal of an emergency.
- 3.Restraint shall be administered only for the period of time necessary to accomplish its purpose and using no more force than is necessary, and prevention of harm to the participant will be the priority if a restraint is administered.

- Required documentation concerning the use of restraints:

- 1.When restraint is used, according to plan or emergency and as soon as possible after, the immediate staff and, if available, witnessing staff will document the use of the restraint, as follows:
- 2.Description of the antecedents (e.g. environmental conditions, activity, who was working with the participant, other individuals in the area) immediately preceding the use;
- 3.The specific behavior being addressed (e.g. number of occurrences, duration, description based on operational definition);
- 4.The alternative strategies used to de-escalate the situation prior to use (e.g. sensory stimulation, choices, redirect to preferred activity);
- 5.How the restraint ended, including physical, medical and behavioral status of the participant (e.g. injuries, medical care provided, 10 seconds of calm and discontinuation of restraint);
- 6.What happened after implementation of the restraint (e.g. participant demonstrated behavior again, participant left the room);
- 7.From on-set of behavior to discontinuation of the restraint, staff reflect on and document the Support Plan strategies they would implement again, or they would use differently;
- 8.Notify care coordinator, as identified in the Support Plan;
- 9.Notify parent/legal guardian, as identified in the Support Plan.

- Education and training requirements that personnel who are involved in the administration of restraints must meet: All service providers implementing restraint must be properly trained and knowledgeable of the following:

- 1.Methods of safely escorting the participant;

2.Methods for safely implementing the restraint;
3.Supervision of the participant while in restraint;
4.Understanding of rules governing restraint practices;
5.Training is conducted within specific timelines of a nationally recognized, best practice training curriculum specific to restraint and should include, at a minimum:
a.Proper use of positive behavior supports, techniques and strategies designed to minimize and prevent the need for use of restraint, such as observing participant and staff behaviors, potentially distressing events, and environmental factors that may trigger emergency safety situations requiring the use of restraint; positive behavior supports includes the use of nonphysical intervention skills such as de-escalation, mediation and conflict resolution, active listening and other verbal and observational methods to detect and prevent emergency safety situations;
b.Safe administration of restraint;
c.Physical safety during emergencies;
d.Identification of the effects of restraint on the participant including physical signs of distress and need for medical attention;
e.Simulated experience of administering and receiving restraint;
f.Proof of appropriate training should be documented in provider staff's personnel file;
g.Methods to explain the use of restraint to parents or caregivers of the participant;
h.Documentation and notification procedures.
All training programs and materials used by the licensed waiver provider will be available for review by CMS, the State Medicaid Agency (KDHE), and KDADS. KDADS staff review training records & interview to ensure compliance with mandatory training. Staff must be able to demonstrate understanding & implementation of the training (including the Support Plan standards).

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Kansas Department for Aging and Disability Services (KDADS) is responsible for monitoring and oversight of the use of restraint. Information and findings are reported to KDHE (Kansas Department of Health and Environment) through quarterly/annual reports during the Long-Term Care Committee meeting.

•Methods for detecting use of restraint and ensuring that all applicable state requirements are followed:

All adverse incidents (including all uses of restraint) are required to be reported into the Adverse Incident Reporting System in accordance with KDADS HCBS Adverse Incident Reporting and Management Standard Policy and KDADS Adverse Incidents Monitoring SOP. This includes DCF reportable incidents of suspected Abuse, Neglect, Exploitation or Fiduciary Abuse perpetrated on a child or adult, after a DCF determination has been made that a specific incident has been screened out, unsubstantiated or substantiated. DCF is statutorily responsible for all Abuse, Neglect, Exploitation and Fiduciary Abuse investigation in accordance with K.S.A. 39-1433 and K.S.A. 38-2226.

All screened out, unsubstantiated, and substantiated determinations by DCF meet the definition of an adverse incident and are entered into the AIR system for remediation and follow-up. For incidents that require follow-up, KDADS staff assign a level of severity to each screened in adverse incident. Depending on the level of severity, KDADS will determine if the incident should require a corrective action plan (CAP), as appropriate, and contact the MCO. MCO CAP remediation efforts and required completion dates are monitored by the appropriate KDADS staff.

•How data are analyzed to identify trends and patterns and support improvement strategies:

KDADS will monitor data within AIR to assess:

1. AIR performance data on each health and welfare performance measure as identified in each HCBS waiver.
2. Trend analysis by each HCBS waiver health and welfare performance measure (i.e. by incident type, by location, etc.).
3. Trend analysis on each adverse incident.
4. Remediation efforts by health and welfare performance measure as identified in each HCBS waiver.
5. Remediation efforts by each adverse incident.

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

Upon completion of statewide and MCO level AIR system data analysis, KDADS reviews the performance measure data reports to determine if there are performance measures that do not meet the state or national benchmarks, and whether the MCO provides comprehensive analysis with details and explanation for any deficiencies.

Based on any identified negative adverse trends associated with specific providers or provider sites, KDADS staff will conduct as needed, site visits to attempt to identify deficiencies that may be a factor associated with the identified negative adverse incident trend or trends.

•The frequency of oversight:

Oversight is ongoing, as indicated in AIRS Policy and Adverse Incident Monitoring Standard Operating Procedure. In addition, the following oversight activities occur related to monitoring MCO performance on investigating and remediation related to adverse incidents:

MCO Adverse Incident Remediation Audit

KDADS will review on a quarterly basis MCO performance in investigating and remediated adverse incidents, including:

1. Reviewing MCO reported adverse incidents within AIRS data to evaluate how well MCOs are taking adequate action to report, resolve, and prevent adverse incidents.
2. Monitoring the time it takes the MCO to refer adverse incidents to the appropriate agency after becoming

aware of the incident.
3. Following up with MCOs to identify systemic concerns and address them through implementation of a corrective action plan or other means, as appropriate.

KDADS will also meet quarterly with MCOs to discuss broader, systemic concerns and identify topics for provider and member education, as appropriate.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one):*

The state does not permit or prohibits the use of restrictive interventions

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The use of restrictive interventions is permitted during the course of the delivery of waiver services Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

- The types of restrictive interventions that are permitted, the circumstances under which they are allowed, and the types of restrictive interventions that are not allowed:

Restrictive interventions are participant-specific and are what the participant and/or their team deems necessary, after other less-restrictive measures such as positive behavior supports have been tried to keep the participant and others around him/her safe. There is not a “listing” of what is permissible, however, a risk assessment is first necessary to determine the necessity of the restriction, a Behavior Management Plan (BMP) must be developed to provide a plan and oversight and then the plan must be reviewed by a Human Rights Committee (HRC) or also known as a Behavior Management Committee (BMC) to review the planned restriction. Some examples of restrictions may be locking food up for those with an eating disorder, or keeping sharps locked up, or one-on-one staff to be available to help de-

The fiscal agent is open to any complaint, concern, or grievance a participant has against a Medicaid provider. The Consumer Assistance Unit staff logs and tracks all complaints, concerns, or grievances which are received in the State’s fiscal agent Call Center and documented in call tracking. This tracking is then routed to the Grievance Unit for investigation. If the grievance situation is urgent the call center staff makes direct contact with the grievance staff immediately.

If a provider has three complaints lodged against them, an investigation is initiated. The fiscal agent team escalates any grievance prior to the three-occurrence timeframe based on the severity of the grievance. Through the escalation processes the fiscal agent team contacts KDADS, KDHE or the appropriate local authority who have access to this information at any time to ensure the member’s safety and wellbeing. The MCOs acknowledge, process and issue responses to all grievances and appeals submitted by a member to their assigned MCO. The MCO staff logs and tracks all grievances and appeals. If a provider has three complaints lodged against him or her, an investigation is initiated. KDHE and KDADS have access to this information at any time.

Participants who are not part of the Kancare program are part of the State’s fee-for-service Medicaid program. Fee-for- service participants have the right to submit grievances to the State’s fiscal agent, KDHE requires the fiscal agent to operate the consumer fee-for-service grievance system consistent with federal regulations. The fiscal agent staff logs and tracks all fee-for- service grievances and fee-for-service state fair hearings. KDHE and KDADS have access to this information at any time. The fiscal agent educates fee-for-service participants that lodging a complaint and/or grievance is not a pre-requisite or substitute for a Fair Hearing and is a separate activity from a Fair Hearing. This information may also be provided by the Waiver Program Manager, or by the Ombudsman’s office escalate a situation or prevent aggressive behaviors to another individual, or self-harm.

- For each type of restrictive intervention that is permitted, the state’s safeguards address:

KDADS staff are responsible for ensuring compliance with regulated safeguards through initial approval and periodic review of agency policies and procedures. For each type of restrictive intervention the following methods are used to avoid the use of restrictive interventions.

In accordance with K.A.R. 30-63-23 providers must take proactive and remedial actions to ensure appropriate, effective, and informed use of medications and other restrictive interventions to manage behavior or to treat diagnosed mental illness. These actions must be taken before the provider initiates the use of any medication or other restrictive intervention unless the needs of the person served clearly dictate otherwise and the provider documents that need. Otherwise, these actions shall be taken promptly following the initiation of, or any change in, the use of any medication or other restrictive intervention to manage behavior or to treat diagnosed mental illness. Such proactive and remedial actions include safeguards (initial and ongoing assessment and responsive modifications that may be needed), management (initial and ongoing assessment and responsive modifications that may be needed), and review by a behavior management committee established by the provider.”

For any restriction of an individual’s access to person, places or thing that put the individual’s health, safety, or welfare at risk, the following should be addressed, in accordance with K.A.R. 30-63-21:

- 1.What is the person’s history of decision-making?
- 2.What are the possible long and short-term consequences associated with poor decision making? (What is the worst that could happen?)

3. What are the possible long and short-term consequences of increased direction and control by staff or system?
4. Existence of safeguards to protect the person's rights.
5. Should more control and direction be provided? If yes, describe the proposed support which causes the least intrusion while adequately protecting the participant.

Review of this information is monitored by KDADS field staff.

A Behavior Support Plan is monitored in accordance with the following standards and is included in the individual's Person-Centered Service Plan.

1. If any restrictive intervention or psychotropic medication being used for or by the person, the person and support team have examined, determined and documented it to be the least restrictive intervention appropriate for this person.
2. If there is any restrictive intervention or psychotropic medication being used for or by the person, positive supports, accommodations and effective services have been considered, documented and are consistently present in the person's life.
3. If there is any restrictive intervention or psychotropic medication being used as a behavior support for or by the person, the behavioral issue being addressed is clearly defined, together with a description of how it's frequency and severity will be measured, as well as a description of how often the support will be reviewed and what criteria will be used for the reduction or elimination (only when appropriate) of the intervention or medication.
4. If there is a restrictive intervention or psychotropic medication being used as a behavior support for or by the person, staff have been trained in the appropriate use of the support, are accurately documenting the frequency and severity of the behavioral issue involved and are consistently providing related positive behavioral supports.
5. If there is a restrictive intervention or psychotropic medication being used as a behavior support for or by the person, the provider is periodically reviewing and reporting to the person, support team and prescribing physician (when applicable), information about the frequency and severity of the behavioral issue involved, effectiveness of the intervention or medication being used, and any medication side effects.

*Methods to detect unauthorized use of restrictive interventions:

Oversight to detect unauthorized use of restrictive interventions and compliance with regulatory standards and statute is conducted by the KDADS Regional Field Staff. On-going review includes interviews with the individual, informal supports and paid staff support and review of person-centered support planning. Additionally, the Community Developmental Disability Organization monitors for compliance with regulatory standards and statute to assure protection from unauthorized restrictive intervention.

As described further in Appendix G-1-b and G-1-d, incidents shall be classified as adverse incidents when the event brings harm or creates the potential for harm to any individual being served by KDADS HCBS waiver program, the Older Americans Act, the Senior Care Act, the Money Follows the Person program, or Behavioral Health Services programs, according to KDADS HCBS Adverse Incident Reporting and Management Standard Policy. These acts include all use of restraints, seclusion and restrictive intervention.

*Protocols for authorizing the use of restrictive interventions, including treatment planning requirements and review/reauthorization procedures:

The proactive and remedial actions include: (1) Safeguards, which shall include initial and ongoing assessment and responsive modifications that may be needed to ensure and documentation of those safeguards, in consultation with the person, the person's guardian, and the person's support network, (2) Management, which shall include initial and ongoing assessment and responsive modifications that may be needed, and (3) Review by a behavior management committee established by the provider.

K.A.R. 30-63-23 requires that voluntary, informed consent has been obtained from the person or the person's guardian if one has been appointed, after a review of the risks, benefits, and side effects, as to the use of any restrictive interventions or medications.

Authorized restrictive interventions should only be used when all less restrictive methods of intervening have been exhausted and are limited to situations in which there is serious, probable and imminent threat of bodily harm to self or others by a person with the present ability to cause such harm. Physical restraints are not allowed for the sole purpose of mediating destruction of property and must never be used as a punitive form of discipline or as a threat to control or gain compliance of a person's behavior. In all situations less restrictive alternatives including, but not limited to, positive behavior supports, constructive, non-physical de-escalation and re-structuring of the environment shall be considered prior to initiating a physical restraint, and all such use will be compliant with Article 63–Developmental Disabilities–Licensing Providers of Community Services.

When restrictive intervention is used, according to plan or emergency and as soon as possible after, the immediate staff and, if available, witnessing staff will document the use of the restrictive intervention as described in the required documentation section below. From on-set of behavior to discontinuation of the restrictive intervention, the staff reflect on and document the Support Plan strategies they would implement again, or they would use differently. Staff shall notify the care coordinator and the parent/legal guardian, as identified in the Support Plan.

Review of this information is monitored by KDADS field staff.

*Required documentation when restrictive interventions are used:

The following must be documented in each participant's Person-Centered Support Plan in accordance with K.A.R. 30-63-21 implementation.

K.A.R. 30-63-23. Medications; restrictive interventions; behavioral management committee.

1.A provider shall take proactive and remedial actions to ensure appropriate, effective, and informed use of medications and other restrictive interventions to manage behavior or to treat diagnosed mental illness. These actions shall be taken before the provider initiates the use of any medication or other restrictive intervention to manage behavior unless the needs of the person served clearly dictate otherwise and the provider documents that need. Otherwise, these actions shall be taken promptly following the initiation of, or any change in, the use of any medication or other restrictive intervention to manage behavior or to treat diagnosed mental illness.

2.These proactive and remedial actions shall include all the following:

a.Safeguards, which shall include initial and ongoing assessment and responsive modifications that may be needed to ensure and document the following, in consultation with the person, the person's guardian, and the person's support network;

b.All other potentially effective, less restrictive alternatives have been tried and shown ineffective, or a determination using best professional clinical practice indicates that less restrictive alternatives would not likely be effective;

c.Positive behavior programming, environmental modifications and accommodations, and effective services from the provider are present in the person's life;

d.Voluntary, informed consent has been obtained from the person or the person's guardian if one has been appointed, after a review of the risks, benefits, and side effects, as to the use of any restrictive interventions or medications; and

e.Medications are administered only as prescribed, and no "PRN" (provided as needed) medications are utilized

without both the express consent of the person or the person's guardian if one has been appointed, and per usage approval from the prescribing physician or another health care professional designated by the person or the person's guardian if one has been appointed.

Additional required documentation:

The field staff monitors for documentation of the standards described above for the Behavior Support Plan in the Person-Centered Support Plan and reviews that evidence services and supports are provided in accordance with the Person-Centered Support Plan. In addition, to these standards, field staff also review the documentation for the following:

1.If there is a restrictive intervention or psychotropic medication being used as a behavior support for or by

the person, the provider is periodically reviewing and reporting to the person, support team and prescribing physician (when applicable), information about the frequency and severity of the behavioral issue involved, effectiveness of the intervention or medication being used, and any medication side effects.

2.A behavior management committee (meeting the membership criteria described in KAR 30-63-23[b][3]) periodically reviews any use of restrictive interventions or psychotropic medication for or by the person to ensure the provisions of KAR 30-63-23 are met, and the provider is responsive to any findings or recommendation by that team.

*Required education and training of personnel involved in authorization and administration of restrictive interventions: Required Restrictive Intervention Training:

KDADS staff monitors waiver providers for evidence of staff training on the following standards in the Person-Centered Support Plan and evidence services and supports are provided in accordance with the Person-Centered Support Plan.

Person-

Centered Support Plan and evidence services and supports are provided in accordance with the Person-Centered Support Plan.

1.The participant, his/her guardian and support network have ongoing, individually-appropriate opportunities to learn about his/her individual rights and responsibilities, including at least annual training offered by the provider.

2.Staff are knowledgeable about and responsible to the person's health services and equipment needs.

3.Staff know how to access the Adult Protective Services contact number; and are knowledgeable about how to identify and report instances of suspected Abuse, Neglect, Exploitation or Fiduciary Abuse.

4.Staff are trained in CPR and first aid are present whenever services are provided.

5.Staff have sufficient knowledge, competence and training to serve the person without oversight by another staff before working alone.

6.If there is a restrictive intervention or psychotropic medication being used as a behavior support for or by the person, staff have been trained in the appropriate use of the support, are accurately documenting the frequency and severity of the behavioral issue involved and are consistently providing related positive behavioral supports.

All staff are required to have been trained on the appropriate use of restrictive interventions, and KDADS staff reviews training records onsite and conducts interviews with staff to determine training has been completed and each individual can demonstrate understanding and implementation of the training. A certified recognized behavior intervention training is required if an individual has restrictive interventions in their plan as an approvable intervention.

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

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

KDADS conducts on-going, on-site, in-person reviews to educate and assess the participant's knowledge, ability and freedom from the use of restrictive interventions. If it is determined that there is suspected unauthorized use, the KDADS Field Staff report immediately. Any areas of vulnerability would be identified for additional training and assurance of non-aversive methods.

"• How data are analyzed to identify trends and patterns and support improvement strategies; and the methods for overseeing the operation of the incident management system including how data are collected, compiled, and used to prevent re- occurrence.

KDADS Field Staff conduct quarterly reviews with the participant and his/her informal supports and paid staff supports to ensure there is no use of restrictive interventions. Additionally, KDADS Field staff review planning for each individual to ensure appropriate supports and services are in place to eliminate the need for restrictive intervention. On the rare occurrence of detection, the incident is addressed immediately. Any areas of vulnerability would be identified for additional training and assurance of non-aversive methods. In the event of a discovery of inappropriate use of restrictive interventions, KDADS quality team has primary oversight responsibility of critical incidents related to safeguards concerning restrictive interventions. However, the MCO will have access to the information on AIR and KDADS will reach out to MCO and notify MCO of incident as appropriate and necessary.

- The frequency of oversight is continuous and ongoing

The Kansas Department for Aging and Disability Services (KDADS) has primary responsibility for overseeing this issue and works with the Kansas Department of Health and Environment (KDHE), as part of the comprehensive KanCare quality improvement strategy to monitor this service issue.

All restrictive interventions are required to be reported to the AIR system. Upon assignment KDADS and the MCO must identify if the use followed all requirements indicated in the Waiver Manual specific to the program in which the recipient is enrolled. If restraint, seclusion or restrictive intervention is utilized for a participant receiving services under the IDD waiver, this will automatically result in an unauthorized use. Utilization of any restraint, seclusion, or restrictive intervention that is not approved by the waiver will result in a Corrective Action Plan.

The use of restrictive interventions is permitted in the waiver and the details regarding authorization will be documented in the Person Centered Service Plan or Behavior Support Plan. The Program Integrity team refers all reported incidents involving restrictive interventions to the appropriate MCO for follow up. The MCO reviews the details of the event, reviews the individuals PCSP/BSP and completes any necessary outreach. The MCO includes details of their follow up in the report which must include if the use of the intervention was authorized or unauthorized. KDADS reviews the notes provided by the MCO, completes the investigation questions and completes the report in the AIR system. For reported unauthorized uses, the MCO follow up must provide detail of the steps taken to ensure the health and welfare of the individual and how the situation was addressed. Reported unauthorized uses of restrictive interventions reflect as non-compliant in the quarterly reports. When there is an increase use of restrictive interventions with one individual or with one provider, the PIC team will communicate this trend to the program manager and KDADS licensing if applicable for additional follow up measures to be taken.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

- c. Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

The state does not permit or prohibits the use of seclusion

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The use of seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

•For each type of seclusion that is permitted, the state's safeguards address these seclusions using the same approach as it does for restrictive interventions. Restrictive intervention language is regulatory language and applies to seclusion as follows:

KDADS staff are responsible for ensuring compliance with regulated safeguards through initial approval and periodic review of agency policies and procedures. For each type of seclusion the following methods are used to avoid the use of seclusion.

For any seclusion of an individual's access to person, places or thing that put the individual's health, safety, or welfare at risk, the following should be addressed, in accordance with K.A.R. 30-63-21:

- 1.What is the person's history of decision-making?
- 2.What are the possible long and short-term consequences associated with poor decision making? (What is the worst that could happen?)
- 3.What are the possible long and short-term consequences of increased direction and control by staff or system?
- 4.Existence of safeguards to protect the person's rights.
- 5.Should more control and direction be provided? If yes, describe the proposed support which causes the least intrusion while adequately protecting the consumer.

Review of this information is monitored by KDADS field staff.

A Behavior Support Plan is monitored in accordance with the following standards and is included in the individual's Person-Centered Service Plan.

- 1.If any restrictive intervention or psychotropic medication being used for or by the person, the person and support team have examined, determined and documented it to be the least restrictive intervention appropriate for this person.
- 2.If there is any seclusion or psychotropic medication being used for or by the person, positive supports, accommodations and effective services have been considered, documented and are consistently present in the person's life.
- 3.If there is any restrictive intervention or psychotropic medication being used as a behavior support for or by the person, the behavioral issue being addressed is clearly defined, together with a description of how it's frequency and severity will be measured, as well as a description of how often the support will be reviewed and what criteria will be used for the reduction or elimination (only when appropriate) of the intervention or medication.
- 4.If there is a restrictive intervention or psychotropic medication being used as a behavior support for or by the person, staff have been trained in the appropriate use of the support, are accurately documenting the frequency and severity of the behavioral issue involved and are consistently providing related positive behavioral supports.
- 5.If there is a restrictive intervention or psychotropic medication being used as a behavior support for or by the person, the provider is periodically reviewing and reporting to the person, support team and prescribing physician (when applicable), information about the frequency and severity of the behavioral issue involved, effectiveness of the intervention or medication being used, and any medication side effects.

*Methods to detect unauthorized use of seclusion:

Oversight to detect unauthorized use of seclusion and compliance with regulatory standards and statute is conducted by the KDADS Regional Field Staff. On-going review includes interviews with the individual, informal supports and paid staff support and review of person-centered support planning. Additionally, the Community Developmental Disability Organization monitors for compliance with regulatory standards and statute to assure protection from unauthorized seclusion.

As described further in Appendix G-1-b and G-1-d, incidents shall be classified as adverse incidents when the event brings harm or creates the potential for harm to any individual being served by KDADS HCBS waiver program, the Older Americans Act, the Senior Care Act, the Money Follows the Person program, or Behavioral Health Services programs, according to KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-

110. These acts include all use of seclusion.

*Protocols for authorizing the use of seclusion, including treatment planning requirements and review/reauthorization procedures:

The proactive and remedial actions include:

- (1) Safeguards, which shall include initial and ongoing assessment and responsive modifications that may be needed to ensure and documentation of those safeguards, in consultation with the person, the person's guardian, and the person's support network,
- (2) Management, which shall include initial and ongoing

assessment and responsive modifications that may be needed, and (3) Review by a behavior management committee established by the provider.

1. A provider shall take proactive and remedial actions to ensure appropriate, effective, and informed use of medications and other restrictive interventions to manage behavior or to treat diagnosed mental illness. These actions shall be taken before the provider initiates the use of any medication or seclusion to manage behavior unless the needs of the person served clearly dictate otherwise and the provider documents that need.

Otherwise, these actions shall be taken promptly following the initiation of, or any change in, the use of any medication or seclusion to manage behavior or to treat diagnosed mental illness.

2. These proactive and remedial actions shall include all the following:

a. Safeguards, which shall include initial and ongoing assessment and responsive modifications that may be needed to ensure and document the following, in consultation with the person, the person's guardian, and the person's support network;

b. All other potentially effective, less restrictive alternatives have been tried and shown ineffective, or a determination using best professional clinical practice indicates that less restrictive alternatives would not likely be effective;

c. Positive behavior programming, environmental modifications and accommodations, and effective services from the provider are present in the person's life;

d. Voluntary, informed consent has been obtained from the person or the person's guardian if one has been appointed, after a review of the risks, benefits, and side effects, as to the use of any seclusion or medications; and

e. Medications are administered only as prescribed, and no "PRN" (provided as needed) medications are utilized

without both the express consent of the person or the person's guardian if one has been appointed, and per usage approval from the prescribing physician or another health care professional designated by the person or the person's guardian if one has been appointed.

In addition, K.A.R. 30-63-23 requires that voluntary, informed consent has been obtained from the person or the person's guardian if one has been appointed, after a review of the risks, benefits, and side effects, as to the use of any restrictive interventions or medications.

Authorized seclusions should only be used when all less restrictive methods of intervening have been exhausted and are limited to situations in which there is serious, probable and imminent threat of bodily harm to self or others by a person with the present ability to cause such harm. Physical restraints are not allowed for the sole purpose of mediating destruction of property and must never be used as a punitive form of discipline or as a threat to control or gain compliance of a person's behavior. In all situations less restrictive alternatives including, but not limited to, positive behavior supports, constructive, non-physical de-escalation and re-structuring of the environment shall be considered prior to initiating a physical restraint, and all such use will be compliant with Article 63–Developmental Disabilities–Licensing Providers of Community Services.

When seclusion is used, according to plan or emergency and as soon as possible after, the immediate staff and, if available, witnessing staff will document the use of seclusion as described in the required documentation section below. From on-set of behavior to discontinuation of seclusion, the staff reflect on and document the Support Plan strategies they would implement again, or they would use differently. Staff shall notify the care coordinator and the parent/legal guardian, as identified in the Support Plan.

Review of this information is monitored by KDADS field staff.

*Required documentation when seclusions are used:

The following must be documented in each participant's Person-Centered Support Plan in accordance with K.A.R. 30-63-21 implementation.

K.A.R. 30-63-23. Medications; restrictive interventions; behavioral management committee.

Additional required documentation:

The field staff monitors for documentation of the standards described above for the Behavior Support Plan in the Person-Centered Support Plan and reviews that evidence services and supports are provided in accordance with the Person-Centered Support Plan. In addition, to these standards, field staff also review the documentation for the following:

1. If there is a seclusion or psychotropic medication being used as a behavior support for or by the person, the provider is periodically reviewing and reporting to the person, support team and prescribing physician (when applicable), information about the frequency and severity of the behavioral issue involved, effectiveness of the seclusion or medication being used, and any medication side effects.

2. A behavior management committee (meeting the membership criteria described in KAR 30-63-23[b][3])

periodically reviews any use of seclusions or psychotropic medication for or by the person to ensure the provisions of KAR 30-63-23 are met, and the provider is responsive to any findings or recommendation by that team.

*Required education and training of personnel involved in authorization and administration of seclusions:

Required Seclusion Training:

KDADS staff monitors waiver providers for evidence of staff training on the following standards in the Person-

Centered Support Plan and evidence services and supports are provided in accordance with the Person-Centered Support Plan.

1.The participant, his/her guardian and support network have ongoing, individually-appropriate opportunities to learn about his/her individual rights and responsibilities, including at least annual training offered by the provider.

2.Staff are knowledgeable about and responsible to the person's health services and equipment needs.

3.Staff know how to access the Adult Protective Services contact number; and are knowledgeable about how to identify and report instances of suspected Abuse, Neglect, Exploitation or Fiduciary Abuse.

4.Staff are trained in CPR and first aid are present whenever services are provided.

5.Staff have sufficient knowledge, competence and training to serve the person without oversight by another staff before working alone.

6.If there is seclusion or psychotropic medication being used as a behavior support for or by the person, staff have been trained in the appropriate use of the support, are accurately documenting the frequency and severity of the behavioral issue involved and are consistently providing related positive behavioral supports.

All staff are required to have been trained on the appropriate use of seclusion, and KDADS staff reviews training records onsite and conducts interviews with staff to determine training has been completed and each individual can demonstrate understanding and implementation of the training. A certified recognized behavior intervention training is required if an individual has seclusion in their plan as an approvable intervention.

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Kansas Department for Aging and Disability Services (KDADS) is responsible for monitoring and oversight of the use of seclusion. Information and findings are reported to KDHE (Kansas Department of Health and Environment) through quarterly/annual reports during the Long-Term Care Committee meeting.

•Methods for detecting use of seclusion and ensuring that all applicable state requirements are followed:

A finding of screened out is given to reports that do not meet the statutory requirements for a DCF investigation. A finding of screened in is given to reports that meet the statutory requirements for a DCF investigation. A DCF screened in report will result in a substantiated or unsubstantiated finding after DCF performs an investigation. All reports from DCF will flow through the AIR system to KDADS once DCF has either screened the report out or made a determination of substantiated or unsubstantiated on a screened in report.

The DCF determination informs KDADS' direction to MCOs on appropriate investigation and remediation steps. All screened out, unsubstantiated, and substantiated determinations by DCF meet the definition of an adverse incident, are "screened in" by KDADS and entered into the AIR system for remediation and follow-up.

All adverse incidents (including all uses of seclusion) are required to be reported into the Adverse Incident Reporting System in accordance with KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110 and KDADS Adverse Incidents Monitoring SOP. This includes DCF reportable incidents of suspected Abuse, Neglect, Exploitation or Fiduciary Abuse perpetrated on a child or adult, after a DCF determination has been made that a specific incident has been screened out, unsubstantiated or substantiated. DCF is statutorily responsible for all Abuse, Neglect, Exploitation and Fiduciary Abuse investigation in accordance with K.S.A. 39-1433 and K.S.A. 38-2226.

All screened out, unsubstantiated, and substantiated determinations by DCF meet the definition of an adverse incident and are entered into the AIR system for remediation and follow-up. For incidents that require follow-up, KDADS staff assign a level of severity to each screened in adverse incident. Depending on the level of severity, KDADS will determine if the incident should require a corrective action plan (CAP), as appropriate, and contact the MCO. MCO CAP remediation efforts and required completion dates are monitored by the appropriate KDADS staff.

•How data are analyzed to identify trends and patterns and support improvement strategies: KDADS will monitor data within AIR to assess:

1. AIR performance data on each health and welfare performance measure as identified in each HCBS waiver.
2. Trend analysis by each HCBS waiver health and welfare performance measure (i.e. by incident type, by location, etc.).
3. Trend analysis on each adverse incident.
4. Remediation efforts by health and welfare performance measure as identified in each HCBS waiver.
5. Remediation efforts by each adverse incident.

KDADS staff provide the Kansas Department of Health and Environment (KDHE) with a report to the LTC Committee detailing the number of screened in and screened out AIR system adverse incident reports and provide an update on all CAPs issued, progress made, and completed.

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

Upon completion of statewide and MCO level AIR system data analysis, KDADS reviews the performance measure data reports to determine if there are performance measures that do not meet the state or national benchmarks, and whether the MCO provides comprehensive analysis with details and explanation for any deficiencies.

Based on any identified negative adverse trends associated with specific providers or provider sites, KDADS staff will conduct as needed site visits to attempt to identify deficiencies that may be a factor associated with the identified negative adverse incident trend or trends.

•The frequency of oversight:

Oversight is ongoing, as indicated in AIRS Policy and Adverse Incident Monitoring Standard Operating Procedure. In addition, the following oversight activities occur related to monitoring MCO performance on investigating and remediation related to adverse incidents:

MCO Adverse Incident Remediation Audit

KDADS will review on a quarterly basis MCO performance in investigating and remediated adverse incidents, including:

- 1.Reviewing MCO reported adverse incidents within AIRS data to evaluate how well MCOs are taking adequate action to report, resolve, and prevent adverse incidents.
- 2.Monitoring the time it takes the MCO to refer adverse incidents to the appropriate agency after becoming aware of the incident.
- 3.Following up with MCOs to identify systemic concerns and address them through implementation of a corrective action plan or other means, as appropriate.

KDADS will also meet quarterly with MCOs to discuss broader, systemic concerns and identify topics for provider and member education, as appropriate.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

No. This Appendix is not applicable (*do not complete the remaining items*)

Yes. This Appendix applies (*complete the remaining items*)

b. Medication Management and Follow-Up

- i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

The entity or entities responsible for ongoing monitoring of participant medication regimens.
Kansas Department for Aging and Disabilities Services Community Supports and Programs (KDADS) Regional Field Staff.

•The scope of monitoring.

Each licensed entity shall maintain records in accordance with K.A.R. 30-63-29; Records.

(a) A provider shall maintain records for each person served. These records shall include the following:

(4) a health profile, which shall be reviewed for accuracy by a licensed medical practitioner at least every two years, and shall include the following:

(A) notations regarding the person's health status;

(B) any medications the person takes; and

(C) any other special medical or health considerations which might exist for that person.

Monitoring is designed to specifically focus on the use of medication to manage behavior or to treat diagnosed mental illness. The following regulated safeguards are monitored for compliance by the licensed provider.

K.A.R. 30-63-23. Medications; behavioral management committee.

•Methods for conducting monitoring.

KDADS Regional Field Staff are responsible for ensuring compliance with regulated safeguards through initial approval and on-going review of agency policies and procedures and regularly scheduled, and at least annually, on-site in-person reviews with persons served by the agency. KDADS Regional Field Staff monitor and assure compliance with:

K.A.R. 30-63-21. Person-Centered Support Planning

K.A.R. 30-63-22. Individual Rights and Responsibilities

K.A.R. 30-63-23. Medications; restrictive intervention; behavioral management committee

K.A.R. 30-63-24. Individual Health

K.A.R. 30-63-25. Staffing; abilities; staff health

K.A.R. 30-63-29. Records

Additionally, the Community Developmental Disability Organization monitors for the above areas of compliance through the Quality Assurance Process, pursuant to regulation.

•Frequency of monitoring.

Each licensed entity is responsible for developing and monitoring participant medication regimens, the methods for conducting monitoring and the frequency of monitoring. Additionally, each licensed entity must assure the state of compliance with the Nurse Practice Act [K.S.A. 65-1124] for providing auxiliary patient care services under the direction of a person licensed to practice medicine or the supervision of a registered professional nurse or a licensed practical nurse. KDADS monitors for licensing compliance with K.A.R. 30-63-25. Individual health:

(b) Non-licensed personnel shall administer medications and perform nursing tasks or activities in conformance with the provisions of K.S.A. 65-1124, and amendments thereto.

•How monitoring has been designed to detect potentially harmful practices and follow-up to address such practices.

Medication regimens are developed by qualified medical personnel according to the individual's specific medical needs as authorized by licensed medical professionals. Training requirements for personnel providing medication administration and restrictive interventions will comply with agency policies and procedures approved by and monitored by KDADS Regional Field Staff.

Medication Training:

The field staff monitors for staff training of the following standards in the Person-Centered Support Plan and evidence services and supports are provided in accordance with the Person-Centered Support Plan through interview and on-site monitoring during the Quality Review process.

1. The person, his/her guardian and the support network have ongoing, individually-appropriate opportunities to learn about his/her individual rights and responsibilities, including at least annual training offered by the provider.

2. Staff are knowledgeable about and responsible to the person's health services and equipment needs.

3. Staff are aware of the medications used by the person; are knowledgeable of the purpose and potential side effects of the medications; and know how to respond effectively if negative side effects occur.

4. Any administration of medication or other nursing tasks or activities are performed only by staff to whom a nurse has trained and delegated the duty and under the nurse's supervision.
5. Staff trained in CPR and first aid are present whenever services are provided.
6. Staff have sufficient knowledge, competence and training to serve the person without oversight by another staff before working alone.
7. If there is a restrictive intervention or psychotropic medication being used as a behavior support for or by the person, staff have been trained in the appropriate use of the support, are accurately documenting the frequency and severity of the behavioral issue involved, and are consistently providing related positive behavioral supports.

• Second line monitoring with regard to use of behavior modifying medications will be reviewed by a behavior management committee established by the provider which meets the criteria established in K.A.R. 30-63-23. Oversight of compliance with the above regulatory standards and statute is conducted by the KDADS Regional Field Staff through on-going, on-site, and in-person review of Person-Centered Support Planning and compliance with regulatory standards. Additionally, the Community Developmental Disability Organization monitors these areas of compliance through the Quality Assurance Process.

Safeguards:

K.A.R. 30-63-23 requires that safeguards, including initial and ongoing assessment and responsive modifications that may be needed to ensure and document the following, in consultation with the person, the person's guardian, and the person's support network (A) All other potentially effective, less restrictive alternatives have been tried and shown ineffective, or a determination using best professional clinical practice indicates that less restrictive alternatives would not likely be effective; (B) positive behavior programming, environmental modifications and accommodations, and effective services from the provider are present in the person's life; (C) voluntary, informed consent has been obtained from the person or the person's guardian if one has been appointed, after a review of the risks, benefits, and side effects, as to the use of any restrictive interventions or medications; and (D) medications are administered only as prescribed, and no "PRN" (provided as needed) medications are utilized without both the express consent of the person or the person's guardian if one has been appointed, and per usage approval from the prescribing physician or another health care professional designated by the person or the person's guardian if one has been appointed.

KDADS conducts on-site, in-person reviews at a minimum quarterly. In the event during the review process, QMS staff discover potentially harmful practices, the QMS staff will issue a finding and request for remediation and/or corrective action plan. QMS staff will require providers to include training as part of the remediation and/or correction plan.

- ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

The state agency (or agencies) responsible for oversight.

Kansas Department for Aging and Disability Services (KDADS) is responsible for oversight and follow-up of appropriate medication management for participants. Information and findings are reported to KDHE (Kansas Department of Health and Environment) through quarterly/annual reports during the Long Term Care Committee Meeting.

•How the state monitoring program gathers information concerning potentially harmful practices and employs such information to improve quality.

Oversight of compliance with regulatory standards and statute is conducted by the KDADS Regional Field Staff through on-going, on-site, and in-person review of Person-Centered Support Planning and compliance with regulatory standards. Specifically, KDADS Regional Field Staff monitor for the use of expired psychotropic medication. Identified issues of non-compliance are directed to the appropriate agency by KDADS Regional Field Staff for follow-up and improvement.

The KDADS Regional Field Staff monitor for compliance with the following regulations to ensure participant medications are managed appropriately and for identification and remediation of potentially harmful practices. These regulations include:

K.A.R. 30-63-21. Person-Centered Support Planning

K.A.R. 30-63-22. Individual Rights and Responsibilities

K.A.R. 30-63-23. Medications; restrictive interventions; behavioral management committee

K.A.R. 30-63-24. Individual Health

K.A.R. 30-63-25. Staffing; abilities; staff health

K.A.R. 30-63-29. Records

Additionally, the Community Developmental Disability Organization monitors the above areas of compliance through the Quality Assurance Process.

Data gathered by KDADS Regional Staff during the Quality Survey Process is provided quarterly to the KDADS Performance Improvement Review Committee [Chaired by the Performance Improvement Program Manager / staffed by PI Staff statewide] for evaluation and trending to identify areas for improvement. Upon completion of identified areas of improvement this information is compiled into an executive report (quarterly and annually) which is submitted to the Performance Improvement Executive Committee [Chaired by the Assistant Director KDADS staffed by Waiver Program Managers, QA Program Manager and PI Program Manager]. The Performance Improvement Executive Committee generates corrective action planning and improvement planning which is submitted to the Director of KDADS-CSP of Operating Agency for review and approval/denial. KDADS Program Manager and Assistant Director present quality reports (quarterly and annually) to the Kansas Department of Health and Environment (KDHE) via the KDHE Long Term Care Committee for review by the State Medicaid Agency (SSMA). Additionally, KDADS is in attendance at the monthly Long Term Care Committee meeting to provide updates with regard to waiver quality processes and HCBS issues as they arise. Whenever a quality reviewer encounters an IDD participant with an identifiable health and/or welfare issue, including medication management issues, the reviewer either:

- 1) makes a referral to APS if, in the reviewer's and his or her supervisor's opinion, the issue involves abuse, neglect, or exploitation of the participant, or
- 2) reports concerns to the MCO or contact person at the managed care entity if the situation is of concern but does not warrant, in the reviewer's opinion, an APS referral. The same standard is used in reporting concerns of potential abuse, neglect, and exploitation to KDADS LCE.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

Not applicable. *(do not complete the remaining items)*

Waiver providers are responsible for the administration of medications to waiver participants who

cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The state's policies concerning the administration of medication to individuals who are unable to self-administer and the responsibilities of providers for overseeing self-administration.

Each licensed entity is responsible for developing and monitoring participant medication regimens, the methods for conducting monitoring and the frequency of monitoring. Additionally, each licensed entity must assure the state of compliance with the Nurse Practice Act [K.S.A. 65-1124] for providing auxiliary patient care services under the direction of a person licensed to practice medicine or the supervision of a registered professional nurse or a licensed practical nurse. KDADS monitors for licensing compliance with K.A.R. 30-63-25. Individual health:

(a) A provider shall assist each person served, as necessary, in obtaining the medical and dental services to which the person has access and that may be required to meet the person's specific health care needs, including the following:

(b) Non-licensed personnel shall administer medications and perform nursing tasks or activities in conformance with the provisions of K.S.A. 65-1124, and amendments thereto.

(c) A provider shall train staff who shall be responsible to implement the service provider's written policies and procedures for carrying out medication administration, including the following:

- (1) Self-administration by any person;
- (2) medication checks and reviews;
- (3) emergency medical procedures; and
- (4) any other health care task.

Medication regimens are developed by qualified medical personnel according to the individual's specific medical needs as authorized by licensed medical professionals. Training requirements for personnel providing medication administration and restrictive interventions will comply with agency policies and procedures approved by and monitored by KDADS/CSP Regional Field Staff.

•If applicable, the training/education that non-medical waiver providers must have in order to administer medications to participants who cannot self-administer and the extent of the oversight of these personnel by licensed medical professionals.

Medication

Training:

The field staff monitors for staff training of the following standards in the Person-Centered Support Plan and evidence services and supports are provided in accordance with the Person-Centered Support Plan through interview and on-site monitoring during the Quality Review process.

- 1.The person, his/her guardian and the support network have ongoing, individually-appropriate opportunities to learn about his/her individual rights and responsibilities, including at least annual training offered by the provider.
- 2.Staff are knowledgeable about and responsible to the person's health services and equipment needs.
- 3.Staff are aware of the medications used by the person; are knowledgeable of the purpose and potential side effects of the medications; and know how to respond effectively if negative side effects occur.
- 4.Any administration of medication or other nursing tasks or activities are performed only by staff to whom a nurse has trained and delegated the duty and under the nurse's supervision.
- 5.Staff trained in CPR and first aid are present whenever services are provided.
- 6.Staff have sufficient knowledge, competence and training to serve the person without oversight by another staff before working alone.
- 7.If there is a restrictive intervention or psychotropic medication being used as a behavior support for or by the person, staff have been trained in the appropriate use of the support, are accurately documenting the frequency and severity of the behavioral issue involved, and are consistently providing related positive behavioral supports.

In accordance with KS statute 65-1124 and 65-6201, Individuals in need of in-home care may receive health maintenance activities, which include medication administration; (m) performance of a nursing procedure by a person when the procedure is delegated by a licensed nurse, within the reasonable exercise of independent nursing judgment and is performed with reasonable skill and safety by that person under the supervision of a registered professional nurse or a licensed practical nurse.

iii. Medication Error Reporting. *Select one of the following:*

Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).

Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

Providers must report all medication errors that result in emergency medical treatment or adverse reaction. Information and findings are reported to KDHE (Kansas Department of Health and Environment) through quarterly/annual reports during the Long-Term Care Committee Meeting.

The State has designed a critical incident reporting system called Adverse Incident Reporting System (AIR). KDADS quality management team will be responsible for the administration and oversight of this reporting process.

The critical incident reporting and review process is designed to facilitate ongoing quality improvement to ensure the health and safety of individuals receiving services by agencies licensed and/or funded by KDADS. It is intended to provide information to improve policies, procedures, and practices.

Each medication error incident shall be reported using the AIR system within 24 hours of the provider becoming aware of the occurrence of the critical incident. Forms are completed and submitted through a secure web-based connection to KDADS.

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

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

If it is determined that an investigation is warranted (including those events designated in Article 63 of the DDRA, 30-63-23, the incident will be investigated by KDADS quality team for confirmation of incidence and work with the MCOs for provider remediation. As a result, the provider may be asked to submit a written corrective action plan. If the corrective action plan does not demonstrate compliance with provider standards, the program's license may be suspended, pending satisfactory resolution of the critical incident. If the critical incident is not resolved within a specified timeline from the date of the initial critical incident, the provider's license may be revoked.

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

Providers must report all medication errors that result in emergency medical treatment or incident. Information and findings are reported to KDHE (Kansas Department of Health and Environment) through quarterly/annual reports during the Long Term Care Committee Meeting.

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

Licensed providers are responsible for reporting any medication errors resulting in injury to the participant which require emergency medical services, hospitalization or death to DCF Adult Protective Services and KDADS.

Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The Kansas Department for Aging and Disability Services-Community Supports and Programs is responsible for oversight and follow-up of waiver provider agencies' performance in administering participant medications.

Data gathered by KDADS Regional Staff during the Quality Survey Process is provided quarterly to the KDADS Performance Improvement Review Committee [Chaired by the Performance Improvement Program Manager / staffed by PI Staff statewide] for evaluation and trending to identify areas for improvement. Upon completion of identified areas of improvement this information is compiled into an executive report (quarterly and annually) which is submitted to the Performance Improvement Executive Committee [Chaired by the Assistant Director of KDADS staffed by Waiver Program Managers, QA Program Manager and PI Program Manager]. The Performance Improvement Executive Committee generates corrective action planning and improvement planning which is submitted to the Director of KDADS, the Medicaid Operating Agency, for review and approval/denial and sent to the Kansas Department of Health and Environment (KDHE) via the KDHE Long Term Care Committee for review by the State Medicaid Agency (SSMA). The approval/denial from the Director of KDADS would be returned to the Performance Improvement Executive Committee for corrective action or planning for implementation of improvement. Additionally, KDADS is in attendance at the monthly Long Term Care Committee meeting to provide updates with regard to waiver quality processes and HCBS issues as they arise.

- Monitoring methods that include the identification of problems in provider performance and support follow-up remediation actions and quality improvement activities.

Statewide/Regional/Provider data is compiled, trended, reviewed, and disseminated to providers through the Performance Improvement Analysis Process. Each provider receives annual data trending which identifies provider specific performance levels related to statewide performance standards and statewide averages. Corrective Action Plan requests and/or technical assistance to remediate negative trending are included in annual provider reports where negative trending is evidenced. The state has a system intervention process in place that allows participants across the state to review cross-service system data to identify trends and opportunities for improvement related to all Kansas waivers, policy and procedure development and systems change initiatives. This systems integration process involves establishing relationships between parties that result in common goals, mission, and philosophy.

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

1. Performance Improvement Data Aggregation (Central Office Performance Improvement Program Manager)
2. Performance Improvement Analysis Process including:
 - a. Community Choice Reflection Team (100% consumer members) review of statewide data versus local provider trends)
 - b. Performance Improvement Review Committee (Central Office PI Program Manager and Regional KDADS field staff)
 - c. Performance Improvement Executive Review Committee (Central Office Assistant Director, Performance Improvement Program Manager and waiver program managers.)
3. Performance Improvement Waiver Report provided to Kansas Department of Health and Environment via the KDHE Long Term Care Committee, for review by the State Medicaid Agency (SSMA).

- How data are acquired to identify trends and patterns and support improvement strategies.

Data gathered by KDADS Regional Staff during the Quality Survey Process is provided quarterly to the KDADS Performance Improvement Review Committee [Chaired by the Performance Improvement Program Manager / staffed by PI Staff statewide] for evaluation and trending to identify areas for improvement. Upon completion of identified areas of improvement this information is compiled into an executive report (quarterly and annually) which is submitted to the Performance Improvement Executive Committee [Chaired by the Assistant Director of KDADS) staffed by Waiver Program Managers, QA Program Manager and PI Program Manager]. The Performance Improvement Executive Committee generates corrective action planning and improvement planning which is submitted to the Director of KDADS, the Medicaid Operating Agency, for review and approval/denial and sent to the Kansas Department of Health and Environment via the KDHE Long Term Care Committee for review by the State Medicaid Agency (SSMA). The approval/denial from the Director of KDADS would be returned to the Performance Improvement Executive Committee for corrective action or planning for implementation of improvement. Additionally, KDADS is in attendance at the monthly Long Term Care Committee meeting to provide updates with regard to waiver quality processes and HCBS issues as they arise. These surveys, reviews and remediation protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly

reviewed and adjusted. (The QIS is reviewed at least annually, and adjusted as necessary based upon that review.) That plan is contributed to and monitored through a state interagency monitoring team, which includes program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. Sub-Assurances:

- a. Sub-assurance:** *The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of Abuse, Neglect, Exploitation (ANE) or unexpected death reported to the OA for which review/investigation followed the appropriate policies and procedures
N=Number of ANE or unexpected death reported to the OA for which review/investigation followed the appropriate policies and procedures
D=Number of ANE or unexpected death reported to the OA.

Data Source (Select one):

Other

If 'Other' is selected, specify:

State System (Adverse Incident Reporting System)

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review

Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Number and percent of ANE and unexpected deaths for which review/investigation resulted in the identification of non-preventable causes N=Number and percent of ANE and unexpected deaths for which review/investigation resulted in the identification of non-preventable causes D=Number of ANE, or unexpected death reported to the OA.

Data Source (Select one):

Other

If 'Other' is selected, specify:

State System (Adverse Incident Reporting System)

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input data-bbox="1078 1093 1264 1178" type="text"/>
Other Specify: <input data-bbox="408 1317 647 1402" type="text"/>	Annually	Stratified Describe Group: <input data-bbox="1078 1317 1264 1402" type="text"/>
	Continuously and Ongoing	Other Specify: <input data-bbox="1078 1541 1264 1626" type="text"/>
	Other Specify: <input data-bbox="718 1765 954 1850" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

b. Sub-assurance: *The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of Adverse Incidents reported to the OA that were initiated and reviewed within the required timeframes
 $N = \text{Number of Adverse Incidents reported to the OA that were initiated and reviewed within the required timeframes}$
 $D = \text{Number of Adverse Incidents reported to the OA}$

Data Source (Select one):

Other

If 'Other' is selected, specify:

State System (Adverse Incident Reporting System)

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

State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	Other Specify: <input type="text"/>

Performance Measure:

Number and percent of APS screen outs, substantiated or unsubstantiated adverse incidents where the OA subsequent review followed the appropriate policies & procedures N= # of APS screen outs, subs. or unsub. adverse incidents where the OA subsequent review followed the appropriate policies & procedures D= # of APS screen outs, subs. or unsub. adverse incidents

Data Source (Select one):

Other

If 'Other' is selected, specify:

State System (Adverse Incident Reporting System)

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>

	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

c. *Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

& % of unauthorized uses of restraint apps, seclusion or other restrictive interventions that followed the appropriate policies & procedures N= # of unauthorized uses of restraint apps., seclusion or other restrictive interventions that followed the appropriate policies & procedures D= # of unauthorized uses of restraint apps., seclusion or other restrictive interventions reported to the OA

Data Source (Select one):

Other

If 'Other' is selected, specify:

State System (Adverse Incident Reporting System)

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Number and percent of unauthorized uses of restraint applications, seclusion or other restrictive interventions that were appropriately reported N=Number of unauthorized uses of restraint applications, seclusion or other restrictive interventions that were appropriately reported D=Number of unauthorized uses of restraint applications, seclusion or other restrictive interventions

Data Source (Select one):

Other

If 'Other' is selected, specify:

State System (Adverse Incident Reporting System)

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify:	Annually	Stratified Describe Group:

	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

d. Sub-assurance: *The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the

method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of waiver participants who have a disaster backup plan N=Number of waiver participants who have a disaster backup plan D=Number of waiver participants whose service plans were reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record Review

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;"> 95% confidence level; +/- 5% margin of error </div>
Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; padding: 2px; width: fit-content;"> Proportionate by MCO </div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>
	Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input data-bbox="406 571 798 660" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input data-bbox="869 862 1260 952" type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Collaboration between the KDADS Field Staff and DCF-APS Social Worker occurs on an on-going basis to review trends and severity of Critical Events. KDADS Field Staff identify trends and severity with TA waiver providers to ensure adequate services and supports are in place. Additionally, KDADS conducts quarterly reviews to educate and assess the consumer’s knowledge and ability and freedom to prevent or report information about Abuse, Neglect, and Exploitation. If it is determined there is suspicion of Abuse, Neglect or Exploitation, the KDADS Field Staff report immediately. Any areas of vulnerability would be identified for additional training and assurance of education.

DCF’s Division of Adult Protective Services is responsible for overseeing the reporting of and response to all critical incidents and events. Adult Protective Services maintains a data base of all critical incidents/events and makes available the contents of the data base to the KDADS and KDHE on an on-going basis. The Performance Improvement Program Manager of KDADS-Community Services and Programs, and the DCF Adult Protective Services Program Manager, and Children and Family Services gather, trend and evaluate data from multiple sources that is reported to the KDADS-Community Services and Programs Director and the State Medicaid Agency.

These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. (The QIS is reviewed at least annually, and adjusted as necessary based upon that review.) That plan which includes program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

b. Methods for Remediation/Fixing Individual Problems

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

KDADS is responsible for oversight of critical events/incidents, and unauthorized use of restraints/restrictive procedures, in accordance with Kansas regulatory and statutory requirements. Oversight of regulatory standards and statute is conducted by KDADS Field Staff.

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

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

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

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;"> Community Developmental Disability Organizations (CDDOs); KanCare Managed Care Organizations (MCOs) </div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

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

The sample for the quarterly desk review is based off of waiver standards and is statistically significant. KDADS has a continual quality review process for the HCBS Performance Measures. This cycle is completed on a quarterly basis, giving continuous feedback to appropriate staff and stakeholders. The KDADS HCBS Quality Management Staff are responsible for desk reviews, for the various Performance Measures located in the waiver. Participants are selected for review based off of a statistically significant sample, pulled by KDADS, according to standards in the waiver.

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

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

KDADS Program Evaluation staff collect data, aggregate it, analyze it and provide information regarding discrepancies and trends to Program staff, Quality Review staff, KDHE staff, MCOs and other management staff. If systemic issues are found, several different remediation strategies are utilized, depending upon the nature, scope and severity of the issues. Strategies include but are not limited to;

- assign remediation plans and/or Quality Improvement Plan(s)
- re-education of best practices
- training of the QR staff to ensure the protocols are utilized correctly
- protocol revisions to capture the appropriate data
- policy clarifications to MCOs to ensure adherence to policy
- Meet with MCO LTSS Directors
- Interagency collaboration with KDHE and DCF.

KDADS compiles a quarterly report containing data for all of the HCBS Performance Measures. Results of these reports are distributed and reviewed internally at KDADS and KDHE, in addition to being posted publicly on the KanCare website. Also submitted by KDHE in KanCare Special Terms and Conditions quarterly and annual reports. KDADS compiles a quarterly report containing data for all of the HCBS Performance Measures. Results of these reports are distributed and reviewed internally at KDADS and KDHE, in addition to being posted publicly on the KanCare website. Also submitted by KDHE in KanCare Special Terms and Conditions quarterly and annual reports.

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Quality Improvement Committee	Annually

Responsible Party(<i>check each that applies</i>):	Frequency of Monitoring and Analysis(<i>check each that applies</i>):
<p>Other Specify:</p> <div style="border: 1px solid black; padding: 2px; width: fit-content;"> KanCare Managed Care Organizations (MCOs) </div>	<p>Other Specify:</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The Kansas Department on Aging (KDADS) and the Division of Health Care Finance within the Kansas Department of Health and Environment monitor and analyze the effectiveness of system design changes using several methods, dependent on the system enhancement being implemented. System changes having a direct impact on HCBS participants are monitored and analyzed through KDADS's Quality Review process. Additional questions may be added to the HCBS Customer Interview Protocols to obtain participant feedback, or additional performance indicators and policy standards may be added to the HCBS Case File Quality Review Protocols. Results of these changes are collected, compiled, reviewed, and analyzed quarterly and annually.

Based on information gathered through the analysis of the Quality Review data and daily program administration, KDADS Program Managers determine if the issues are systemic or an isolated instance or issue. This information is reviewed to determine if training to a specific Managed Care Organization is sufficient, or if a system change is required.

The Kansas Assessment Management Information System (KAMIS) is currently the official electronic repository of data about KDADS customers and their received services. This customer-based data is used by KDADS and the MCOs to coordinate activities and manage HCBS programs. System changes are made to KAMIS to enhance the availability of information on participants and performance. Improvements to the KAMIS system are initiated through comments from stakeholders, KDADS Program Managers, and Quality Review staff, and approved and prioritized by KDADS management. Effectiveness of the system design change is monitored by KDADS's Program Managers, working in concert with KDADS's Quality Review and Program Evaluation staff.

DHCF-KDHE contracts with DXC to manage the Medicaid Management Information System (MMIS). Improvements to this system require DHCF-KDHE approval of the concept and prioritization of the change. KDADS staff work with DHCF-KDHE and DXC staff to generate recommended systems changes, which are then monitored and analyzed by the fiscal agent and KDADS to ensure the system change operates as intended and meets the desired performance outcome.

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

Quarterly and as needed, KDHE and KDADs will meet monthly in their LTC meeting, to evaluate trends reflected in the HCBS Quality Review Reports and identify areas for improvement.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

- a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):

No

Yes (*Complete item H.2b*)

b. Specify the type of survey tool the state uses:

HCBS CAHPS Survey :

NCI Survey :

NCI AD Survey :

Other (Please provide a description of the survey tool used):

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Based on signed provider agreements, each HCBS provider is required to permit the Kansas Department of Health and Environment, the Kansas Department for Aging and Disabilities (KDADS), their designee, or any other governmental agency acting in its official capacity to examine any records and documents that are necessary to ascertain information pertinent to the determination of the proper amount of a payment due from the Medicaid program. Additionally, the Division of Legislative Post Audit contracts with an independent accounting firm to complete Kansas' statewide single audit on an annual basis. The accounting firm must comply with all requirements contained in the single audit act. The Medicaid program, including all home and community-based services waivers is a required component of the single state audit. Independent audits of the waiver will look at cost-effectiveness, the quality of services, service access, and the substantiation of claims for HCBS payments. These issues are addressed in a variety of ways, including: statewide single annual audit; annual financial and other audits of the KanCare MCOs; encounter data, quality of care and other performance reviews/audits; and audits conducted on HCBS providers. There are business practices of the state that result in additional ongoing audit activities that provide infrastructure/safeguards for the HCBS programs, including:

- a. Because of other business relationships with the state, each of the following HCBS provider entities are required to obtain and submit annual financial audits, which are reviewed and used to inform their Medicaid business with Kansas: Area Agencies on Aging; Community Mental Health Centers; Community Developmental Disability Organizations; and Centers for Independent Living.
- b. As a core provider requirement, FMS providers must obtain and submit annual financial audits, which are reviewed and used to monitor their Medicaid business with Kansas.

The state conducts a 5% (95/5) sample for case files reviews of MCOs and Assessors, the sample results in a 95% confidence level and a +/- 5% confidence interval.

Under the KanCare program, payment for services is being made through the monthly pmpm paid by the state to the contracting MCOs. (The payments the MCOs make to individual providers, who are part of their networks and subject to contracting protections/reviews/member safeguards.) Payments to MCOs are subject to ongoing monitoring and reporting to CMS, consistent with the Special Terms and Conditions issued with approval of the related 1915(b) waiver. Those STCs include both monitoring of budget neutrality as well as general financial requirements, and also a robust evaluation of that demonstration project which addresses the impact of the KanCare program on access to care, quality, efficiency, coordination of care, and the cost of care. Per the 1915(b) Native Americans are able to opt out of Managed Care at any time.

Eligibility is received from Kansas Eligibility Enforcement System (KEES, the state's system for determining eligibility. Capitation payments are made based off a rate cell that is set by Population Codes, Level of Care, Age or any combination of those. Members will qualify for HCBS rate cells based off of their Level of Care.

Per the 1915(b) Native Americans are able to opt out of Managed Care at any time. Waiver services can be furnished on an FFS basis. The claims are processed through the claims engine based on the beneficiary's benefit plan. This benefit plan will cause the system to look for a PA for the beneficiary. The PA should include the code and the dates of service submitted on the claim. Claims will deny if a PA is not found or does not pertain to the information on the claim. The provider will be paid the rate on file for the procedure code or the rate on the PA. All FFS claims are monitored for accuracy by the DXC SURS team. If determined a provider was paid for services not rendered under FFS, the claim would be adjusted to recoup the funds paid.

In addition, these services - as part of the comprehensive KanCare managed care program - will be part of the corporate compliance/program integrity activities of each of the KanCare MCOs. That includes both monitoring and enforcement of their provider agreements with each provider member of their network and also a robust treatment, consistent with federal regulation and state law requirements, of prevention, detection, intervention, reporting, correction and remediation program related to fraud, waste, abuse or other impropriety in the delivery of Medicaid services under the KanCare program. The activities include comprehensive utilization management, quality data reporting and monitoring, and a compliance officer dedicated to the KanCare program, with a compliance committee that has access to MCO senior management. As those activities are implemented and outcomes achieved, the MCOs will be providing regular and ad hoc reporting of results. KDHE will have oversight of all portions of the program and the KanCare MCO contracts, and will collaborate with KDADS regarding HCBS program management, including those items that touch on financial integrity and corporate compliance/program integrity. The key component of that collaboration will be through the interagency monitoring team, an important part of the overall state's KanCare Quality Improvement Strategy, which will provide quality review and monitoring of all aspects of the KanCare program – engaging program management, contract management, and financial management staff from both KDHE and KDADS.

Some of the specific contractual requirements associated with the program integrity efforts of each MCO include:

Coordination of Program Integrity Efforts.

The CONTRACTOR shall coordinate any and all program integrity efforts with KDHE/DHCF personnel and Kansas' Medicaid Fraud Control Unit (MFCU), located within the Kansas Attorney General's Office. At a minimum, the CONTRACTOR shall:

- a. Meet monthly, and as required, with the KDHE/DHCF staff and MFCU staff to coordinate reporting of all instances of credible allegations of fraud, as well as all recoupment actions taken against providers;
- b. Provide any and all documentation or information upon request to KDHE/DHCF or MFCU related to any aspect of this contract, including: policies, procedures, subcontracts, provider agreements, claims data, encounter data, and reports on recoupment actions and receivables;
- c. Report immediately or within 24 hours of becoming aware of the allegation of abuse, fraud or waste to the KDHE/DHCF, MFCU, and any appropriate legal authorities any evidence indicating the possibility of fraud and abuse by any member of the provider network; if the CONTRACTOR fails to report any suspected fraud or abuse, the State may invoke any penalties allowed under this contract including, but not limited to, suspension of payments or termination of the contract. Furthermore, the enforcement of penalties under the contract shall not be construed to bar other legal or equitable remedies which may be available to the State or MFCU for noncompliance with this section;
- d. Provide KDHE/DHCF with a quarterly update of investigative activity, including corrective actions taken;
- e. Hire and maintain a staff person in Kansas whose duties shall be composed at least 90% of the time in the oversight and management of the program integrity efforts required under this contract. This person shall be designated as the Program Integrity Manager. The program integrity manager shall have open and immediate access to all claims, claims processing data and any other electronic or paper information required to assure that program integrity activity of the CONTRACTOR is sufficient to meet the requirements of the KDHE/DHCF. The duties shall include, but not be limited to the following:
 - (1) Oversight of the program integrity function under this contract;
 - (2) Liaison with the State in all matters regarding program integrity;
 - (3) Development and operations of a fraud control program within the CONTRACTOR claims payment system;
 - (4) Liaison with Kansas' MFCU;
 - (5) Assure coordination of efforts with KDHE/DHCF and other agencies concerning program integrity issues.

KDHE is responsible for Provider enrollment with the Medicaid fiscal agent. KDADS performs various reviews and audits of the MCOs regarding HCBS including but not limited to report reviews, quarterly case file reviews, annual reviews, provider qualification reviews.

The claims engine is referencing the Medicaid Management Information System (MMIS) claims engine. The MMIS is a part of the Medicaid fiscal agent contract.

EVV is the sole approved claims entry point for EVV-required services in Kansas. Claims must be submitted through EVV, using MCO authorizations, caregiver visits, and provider administration data. Provider Administrators validate all information and address exceptions before claim submission. Claims that are not submitted for any EVV covered services through the EVV system are denied.

Services covered under EVV are PCS, ECS, Overnight Respite, SMC, FMS and SHC.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

- a. **Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the**

reimbursement methodology specified in the approved waiver and only for services rendered.
 (Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of clean claims that are paid by the managed care organization within the timeframes specified in the contract
 $N = \text{Number of clean claims that are paid by the MCO within the timeframes specified in the contract}$
 $D = \text{Total number of provider claims paid by the MCO}$

Data Source (Select one):

Other

If 'Other' is selected, specify:

MCO Reports

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>

	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of payment rates that were certified to be actuarially sound by the State's actuary and approved by CMS throughout the five year waiver cycle
 $N = \text{Number of payment rates that were certified to be actuarially sound by the State's actuary and approved by CMS}$
 $D = \text{Total \# of capitation (payment) rates}$

Data Source (Select one):

Other

If 'Other' is selected, specify:

Actuary Documentation

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<i>State Medicaid Agency</i>	<i>Weekly</i>	<i>100% Review</i>
<i>Operating Agency</i>	<i>Monthly</i>	<i>Less than 100% Review</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>	<i>Representative Sample</i> <i>Confidence Interval =</i> <input type="text"/>
<i>Other</i> <i>Specify:</i> <input type="text"/>	<i>Annually</i>	<i>Stratified</i> <i>Describe Group:</i> <input type="text"/>
	<i>Continuously and Ongoing</i>	<i>Other</i> <i>Specify:</i> <input type="text"/>
	<i>Other</i> <i>Specify:</i> <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other</i> <i>Specify:</i>	<i>Annually</i>

<i>Responsible Party for data aggregation and analysis (check each that applies):</i>	<i>Frequency of data aggregation and analysis (check each that applies):</i>
<input type="checkbox"/>	
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Kansas established interagency monitoring to ensure effective interagency coordination as well as overall monitoring of MCO contract compliance. This work will be governed by the comprehensive state Quality Improvement Strategy for the KanCare program, a key component of which is the interagency monitoring that engages program management, contract management and financial management staff of both KDHE and KDADS.

b. Methods for Remediation/Fixing Individual Problems

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

These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through interagency monitoring, which includes program managers, contract managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency. State staff request, approve, and assure implementation of contractor corrective action planning and/or technical assistance to address non-compliance with performance standards as detected through on-site monitoring, survey results and other performance monitoring. These processes are monitored by both contract managers and other relevant state staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy and the operating protocols of interagency monitoring.

ii. Remediation Data Aggregation

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

<i>Responsible Party (check each that applies):</i>	<i>Frequency of data aggregation and analysis (check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> KanCare MCOs contracting with the State of Kansas	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

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

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

Managed Care (KanCare)

Under the KanCare comprehensive managed care program, capitation rates are established consistent with federal regulation requirements, by actuarially sound methods, which take into account utilization, medical expenditures, program changes and other relevant environmental and financial factors. HCBS rates are considered in capitation rate development. The resulting capitation rates are certified to and approved by CMS.

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

Adjustments to HCBS rates are subject to legislative appropriation. Any increases to HCBS rates as appropriated by the state legislature are considered as a policy change in the actuarial rate setting of capitation payments.

HCBS rates set by the state are the floor rates in managed care. The rates are the minimum required to be paid by MCOs, but actual rates are negotiated by the provider through the contracting process. The State's Managed Care Organizations (MCOs) can contract at rates at or above the rates set in the State's Fee Schedule as is appropriate for meeting a HCBS Waiver members needs in the community.

All HCBS fee schedule rates are made available via the Kansas Medical Assistance Program (KMAP) Website.

The 2024 HCBS Rates are located here: <https://portal.kmap-state-ks.us/Documents/Provider/Bulletins/UPDATED%203151%20-%20General%20-%20HCBS%20Rate%20Changes%20for%20Fiscal%20Year%202024%20-%20With%20Table.pdf>

There are periodic checks of the rates and utilization for each of the services on the waiver. The State has leveraged, and will continue to leverage, multiple sources to assist in researching the adequacy of our rates. This would include strategies such as engaging with a consulting group to provide a rate study of surrounding states to benchmark where Kansas rates rank. The State also periodically requests that the MCOs review rates for similar services in other markets that they serve. Additionally, the State has open lines of communication with various provider groups, and welcomes research performed by such groups as another data point. The Operating Agency seeks feedback from stakeholders and have included requests for rate adjustments for HCBS. The goal of the state is to ensure that the rates for waiver services are sufficient to encourage providers to continue serving the waiver population, thus maintaining network adequacy.

Specifically for HCBS/IDD, there is a state statute (K.S.A. 39-1801 et.al, aka The Developmental Disabilities Reform Act (DDRA)) that requires an independent, professional review of the rate structures on a biennial basis resulting in a recommendation to the legislature regarding rate adjustments.

Fee For Service (FFS)

In the rare event of a member opting out of managed care, FFS claims would be paid with FFS rates per the fee schedule.

HCBS Fee For Service rates in the fee schedule are based on legislative appropriation.

The State ensures FFS rates are adequate by ensuring a provider network is available in the rare event there is an opt out from Managed Care. In the event there are no FFS providers available due solely to the FFS rate, the state would make necessary adjustments to ensure providers are available.

All HCBS fee schedule rates are made available via the Kansas Medical Assistance Program (KMAP) Website.

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

Claims for services are submitted to the MCOs directly from waiver provider agencies or from Financial Management Service (FMS) agencies for those individuals self-directing their services. All claims are either submitted through the EVV system, the State's front-end billing solution, or directly to the MCO either submitted through paper claim format or through electronic format.

Claims for services required in the EVV system are generated from that system. Capitated payments in arrears are made only when the participant was eligible for the Medicaid waiver program during the month.

Claims are received via electronic or paper media. Electronic claims are separated out between MCO and FFS based on the Beneficiary ID and the first date of service on the claim compared with the eligibility file. The claims, where assignment to an MCO is found for that date of service, are sent to the MCO for processing. Claims without an MCO assignment are processed FFS.

Paper claims are sent back to the provider if it can be determined the beneficiary is assigned to an MCO. Otherwise, the claims are processed through the MMIS claims engine and deny if the beneficiary is assigned to an MCO or process through the MMIS claims engine if not assigned.

The claims are processed through the MMIS claims engine based on the beneficiary's benefit plan. This benefit plan will cause the system to look for a PA for the beneficiary. The PA should include the code and the dates of service submitted on the claim. Claims will deny if a PA is not found or does not pertain to the information on the claim. The provider will be paid the rate on file for the procedure code or the rate on the PA.

In Kansas, Community Developmental Disability Organizations (CDDOs) are responsible for acting as the single point of entry for IDD services and are also responsible for functional assessments for the IDD Waiver. CDDOs are reimbursed for these administrative services and functional assessments through contractual agreement between the State and each CDDO. These functions are reimbursed to CDDOs through the KDADS Management information System (MIS) and the State's Accounting System. It should also be noted that while the CDDO conducts the functional assessment, the eligibility determination is made by the State.

Appendix I: Financial Accountability

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

c. Certifying Public Expenditures (select one):

No. state or local government agencies do not certify expenditures for waiver services.

Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

Certified Public Expenditures (CPE) of State Public Agencies.

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

Certified Public Expenditures (CPE) of Local Government Agencies.

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

Appendix I: Financial Accountability

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

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

A capitated payment is made to the MCOs for each month of Waiver eligibility. This is identified through Kansas Eligibility Enforcement System (KEES), the State's eligibility system.

The state has been using an approved Electronic Visit Verification system for Personal Care Services since 2012. The State's eligibility system, along with plans of care in the Kansas Medical Management System assure that only services approved in the member's plan of care are reimbursed. As of 12/3/23, the State is fully compliant with the 21st Century CURES Act.

Services subject to EVV pre-payment review will be Agency-directed Personal Care Services, Personal Care Services (Self-Directed), Financial Management Services, Enhanced Care Services, Specialized Medical Care and Respite Care. Visit information is captured in the EVV system, and processed through the rules engine to identify exceptions. Those exceptions are then worked within the EVV system. The EVV system creates the claims for validated visits.

Currently the State of Kansas is performing comparisons outside of the EVV system matching all Paid Claims for EVV Services against visits logged in the EVV system. Caregiver Visits are captured in the EVV system and then run through a rules engine to ensure compliance against a list of requirements that eliminate duplications, errors and fraudulent entries. We are matching at a rate of 92%. Paid claims that do not match to an EVV record are being followed up on by the EVV Team to notify the providers of the discrepancy. If the rate of non-compliance is unacceptable, we are working to put them on a corrective action plan. This process is just getting underway as we have passed through our first quarter of both HHCS/HCBS-PCS EVV requirements.

Meanwhile, we are completing development on a pre-claims EVV requirement whereby, caregiver visits are captured in the EVV system, run through the rules engine, providers work to clear any exceptions and then the visit data becomes the basis for claims submittals- with any claim submitted outside of the EVV system being rejected by either the MCO or the state's fiscal agent using Front End Billing logic (FEB). We anticipate the Claims Processing capability to be fully operational by January of 2025.

Paid claims are matched to the EVV system claims in the EVV system.

Post payment billings are conducted by the MCOs.

The State's Quality Management Staff (QMS) conducts quarterly and annual reviews, which includes reviewing case file documentation to see if choice was provided and if the participant signed the Choice document. Additionally, participant interviews have been completed, inquiring if they were provided choice. During the interview of the participant QMS identifies if a provider choice form was presented to the family, asks how the provider choice was decided and if services were rendered according to those identified on the participant's Service Plan.

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

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

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

Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).

Payments for some, but not all, waiver services are made through an approved MMIS.

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

Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

The MMIS Managed Care system assigns participants to one of the three KanCare Plans. Each assignment generates an assignment record, which is shared with the plans via an electronic record.

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

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.

The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.

The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

All of the waiver services in this program are included in the state's contract with the KanCare MCOs. A member may be self-directing, but they are still in managed care, assigned to an MCO. The member will not enter into an FFS environment, therefore the fiscal agent is not involved.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

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

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

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

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

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

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

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

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

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

In some instances there are county level government agencies, i.e., CDDOs/providers that provide services. These county level government agencies are CDDO/providers These services include, all waiver services including, Residential Supports, Day Supports, PCS, ECS, Home and Environmental Modification Services Vehicle Modification Services, Specialized Medical Equipment and Supplies, Overnight Respite, FMS, Wellness Monitoring, Supported Employment, and Medical Alert Rental, Specialized Medical Care, Children's Integrated Community Supports.

The state contracts with 27 CDDOs with five being tied to their county government. The five CDDOs that are a part of county level government serve as both a CDDO and a provider.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

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

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

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

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

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

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

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

Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.

Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

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

No. The monthly capitated payments to the MCOs are not reduced or returned in part to the state. Anyone received their services through FFS, the provider would retain 100% of the amount claimed.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:

No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. Select one:

No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how

payments to these plans are made.

This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

Appropriation of State Tax Revenues to the State Medicaid agency

Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

The non-federal share of the waiver expenditures is from direct state appropriations to the Department for Aging and Disability Services (KDADS), through agreement with the Single State Medicaid Agency, Kansas Department of Health and Environment(KDHE), as of July 1, 2012. The non-federal share of the waiver expenditures are directly expended by KDADS. Medicaid payments are processed by the State's fiscal agent through the Medicaid Management Information System using the InterChange STARS Interface System (iCSIS). iCSIS contains data tables with the current federal and state funding percentages for all funding types. State agencies are able to access iCSIS's reporting module to identify payments made by each agency. KDHE – Division of Health Care Finance draws down federal Medicaid funds for all agencies based on the summary reports from iCSIS. Interfund transfers to the other state agencies are based on finalized fund summary reports. The full rate will be expended on capitation payments in the KanCare program.. In the event an individual opts out of managed care, fee for services payments will be made via the state's MMIS via the process indicated above.

Other State Level Source(s) of Funds.

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:

Not Applicable. There are no local government level sources of funds utilized as the non-federal share.

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:

None of the specified sources of funds contribute to the non-federal share of computable waiver costs

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability**I-5: Exclusion of Medicaid Payment for Room and Board**

a. Services Furnished in Residential Settings. Select one:

No services under this waiver are furnished in residential settings other than the private residence of the individual.

As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:

When establishing reimbursement rates as described in Appendix I2 - a., no expenses associated with room and board are considered. The costs of room and board are not a consideration when determining reimbursement rates. Only direct service costs are considered.

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

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

Appendix I: Financial Accountability**I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver**

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:

No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)**

a. Co-Payment Requirements. Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:

No. The state does not impose a co-payment or similar charge upon participants for waiver services.

Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

Nominal deductible

Coinsurance

Co-Payment

Other charge

Specify:

[Empty rectangular box for specifying charges]

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	62137.79	17008.00	79145.79	55886.00	37298.00	93184.00	14038.21
2	62137.79	17008.00	79145.79	55886.00	37298.00	93184.00	14038.21
3	62137.79	17008.00	79145.79	55886.00	37298.00	93184.00	14038.21
4	62137.79	17008.00	79145.79	55886.00	37298.00	93184.00	14038.21
5	62137.79	17008.00	79145.79	55886.00	37298.00	93184.00	14038.21

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		ICF/IID	
Year 1	9895		9895
Year 2	9895		9895
Year 3	9895		9895
Year 4	9895		9895
Year 5	9895		9895

Appendix J: Cost Neutrality Demonstration

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

The average length of stay estimate is derived from the unduplicated participants and the total days of actual waiver coverage from the CMS-372 reports for Waiver Years 2 and 3 (07/01/2020-06/30/2022). Based on that analysis, the State used an estimated average of 354 for the upcoming waiver period.

Based on programmatic assumptions, the State has no trends or indicators at this point to assume an increase or decrease in ALOS over the waiver period.

The ALOS is assumed to remain constant because most participants remain enrolled until they move out of state or pass away. Additionally, since this is a mature waiver, it is assumed that the yearly turnover and length of waiver experience will remain stable.

Appendix J: Cost Neutrality Demonstration

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

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

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

Factor D was estimated by utilizing Managed Care encounter data from the Kansas Medicaid Management Information System and analyzing trends of annual utilization from SFY2022 through SFY2023 – 07/01/2021 through 06/30/2023. This is an estimate of MCO encounters and is not reflective of the State's capitation payments made to the MCO.

The State has added Children's Integrated Community Supports as a new service to this waiver. The State reviewed Managed Care encounter data from the Kansas Medicaid Information System and evaluated trends of utilization from June 2021 through July 2023 for the existing waiver services. Based upon programmatic knowledge and assumptions, the State made its best estimate to project utilization for the new waiver service. The State assumed that approximately 85 waiver participants would utilize this service and does not currently assume that there will be significant growth over the five years.

For Supported Employment, Medical Alert Rental, and Overnight Respite Care: The State assumes a slight increase in these services based upon waiver growth trends and utilization from July 2021 through June 2023.

For Personal Care Services – Agency Direct: The State adjusted the estimated units per user to take into consideration that some waiver participants would be utilizing the new waiver service.

For Day Supports and Wellness Monitoring: The State modified the estimated number of participants to better align with waiver trends and utilization noted from July 2021 through June 2023.

The average cost/unit or unit rate for all existing waiver services was updated to reflect the State Fiscal Year 2024 waiver service payment rates. These per unit costs are based on the existing rate structure and applicable legislative rate increases that were effective 07/01/2023.

For the waiver renewal period, there is no growth rate applied to Factor D, as the State does not currently anticipate that there will be a significant change in rates over the next five years, as rate increases are dependent upon appropriation from the Kansas Legislature each year.

- ii. Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' is projected by obtaining a two-year average (SFY2022 through SFY2023 – 07/01/2021 through 06/30/2023) of waiver capitation costs less a two-year average (SFY2022 through SFY2023 – 07/01/2021 through 06/30/2023) of MCO encounter payment costs. The waiver capitation costs and MCO encounter payment costs are derived from the Kansas Medicaid Management Information System.

In Kansas, Factor G' has historically been greater than D'. This is primarily attributed to the costs of hospice and dental anesthesia services being included as part of the State Plan G' services. Over 50% of G' costs are attributed to these two services for this population.

For the waiver renewal period, there is no growth rate applied to Factor D', as the State does not currently anticipate that there will be a significant change in rates over the next five years, as rate increases are dependent upon appropriation from the Kansas Legislature each year.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G is estimated by utilizing encounter data from the Kansas Medicaid Management Information System and reflects MCO payments to the institutional providers, using a two-year average (SFY2022 through SFY2023 – 07/01/2021 through 06/30/2023). This is an estimate of MCO encounters and is not reflective of the State's capitation payments made to the MCO.

For the waiver renewal period, there is no annual trending applied to Factor G. The State has not included any assumptions that there will be a significant change in institutional costs over the next five years for this population. It should also be noted that floor rates in Kansas Medicaid are determined by legislative appropriation.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G' is projected by obtaining a two-year average (SFY2022 through SFY2023 – 07/01/2021 through 06/30/2023) of the institutional alternative capitation costs minus a two-year average (SFY2022 through SFY2023 – 07/01/2021 through 06/30/2023) of MCO institutional alternative encounter payment costs. The institutional capitation costs and MCO encounter payment costs are derived from the Kansas Medicaid Management Information System.

For the waiver renewal period, there is no annual trending applied to Factor G'. The State does not currently anticipate that there will be a significant change in rates over the next five years. It should also be noted that floor rates in Kansas Medicaid are determined by legislative appropriation.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “manage components” to add these components.*

Waiver Services	
Day Supports	
Overnight Respite Care	
Personal Care Service (PCS)	
Residential Supports	
Supported Employment (SE)	
Financial Management Services (FMS)	
Children's Integrated Community Supports (CHICS)	

Waiver Services	
Enhanced Care Service	
Home and Environmental Modification Services (HEMS)	
Medical Alert Rental	
Specialized Medical Care	
Specialized Medical Equipment and Supplies (SMES)	
Vehicle Modification Services (VMS)	
Wellness Monitoring	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Supports Total:							165357360.00
Day Supports	<input type="checkbox"/>	15 minutes	6540	4200.00	6.02	165357360.00	
Overnight Respite Care Total:							478674.00
Overnight Respite Care	<input type="checkbox"/>	1 day	200	21.00	113.97	478674.00	
Personal Care Service (PCS) Total:							93687800.00
Personal Care Services - Self-Directed	<input type="checkbox"/>	15 minutes	3300	6400.00	4.14	87436800.00	
Personal Care Services - Agency-Directed	<input type="checkbox"/>	15 minutes	400	3325.00	4.70	6251000.00	
Residential Supports Total:							334555146.80
Residential Supports	<input type="checkbox"/>	1 day	5462	335.00	182.84	334555146.80	
Supported Employment (SE) Total:							1083975.00
Supported	<input type="checkbox"/>					1083975.00	
GRAND TOTAL:							614853412.30
Total: Services included in capitation:							614853412.30
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							9895
Factor D (Divide total by number of participants):							62137.79
Services included in capitation:							62137.79
Services not included in capitation:							
Average Length of Stay on the Waiver:							354

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Employment (SE)		15 minutes	250	970.00	4.47		
Financial Management Services (FMS) Total:							6197862.00
Financial Management Services (FMS)		1 month	3300	11.00	170.74	6197862.00	
Children's Integrated Community Supports (CHICS) Total:							517140.00
Children's Integrated Community Supports (CHICS)		15 minutes	85	3900.00	1.56	517140.00	
Enhanced Care Service Total:							3931965.00
Enhanced Care Service		6-12 hours	150	230.00	113.97	3931965.00	
Home and Environmental Modification Services (HEMS) Total:							130680.00
Home and Environmental Modification Services (HEMS)		1 purchase	8	1.00	16335.00	130680.00	
Medical Alert Rental Total:							41477.00
Medical Alert Rental		1 month	190	10.00	21.83	41477.00	
Specialized Medical Care Total:							8618625.00
Specialized Medical Care (RN)		15 minutes	33	4500.00	11.75	1744875.00	
Specialized Medical Care (LPN)		15 minutes	78	7500.00	11.75	6873750.00	
Specialized Medical Equipment and Supplies (SMES) Total:							21780.00
Specialized Medical Equipment and Supplies		1 purchase	33	1.00	660.00	21780.00	
GRAND TOTAL:							614853412.30
Total: Services included in capitation:							614853412.30
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							9895
Factor D (Divide total by number of participants):							62137.79
Services included in capitation:							62137.79
Services not included in capitation:							
Average Length of Stay on the Waiver:							354

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
(SMES)							
Vehicle Modification Services (VMS) Total:							65340.00
Vehicle Modification Services (VMS)	<input type="checkbox"/>	1 purchase	5	1.00	13068.00	65340.00	
Wellness Monitoring Total:							165587.50
Wellness Monitoring	<input type="checkbox"/>	1 visit	650	5.00	50.95	165587.50	
GRAND TOTAL:							614853412.30
Total: Services included in capitation:							614853412.30
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							9895
Factor D (Divide total by number of participants):							62137.79
Services included in capitation:							62137.79
Services not included in capitation:							
Average Length of Stay on the Waiver:							354

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Supports Total:							165357360.00
Day Supports	<input type="checkbox"/>	15 minutes	6540	4200.00	6.02	165357360.00	
Overnight Respite Care Total:							478674.00
Overnight Respite Care	<input type="checkbox"/>	1 day	200	21.00	113.97	478674.00	
Personal Care Service (PCS) Total:							93687800.00
GRAND TOTAL:							614853412.30
Total: Services included in capitation:							614853412.30
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							9895
Factor D (Divide total by number of participants):							62137.79
Services included in capitation:							62137.79
Services not included in capitation:							
Average Length of Stay on the Waiver:							354

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care Services - Self-Directed		15 minutes	3300	6400.00	4.14	87436800.00	
Personal Care Services - Agency-Directed		15 minutes	400	3325.00	4.70	6251000.00	
Residential Supports Total:							334555146.80
Residential Supports		1 day	5462	335.00	182.84	334555146.80	
Supported Employment (SE) Total:							1083975.00
Supported Employment (SE)		15 minutes	250	970.00	4.47	1083975.00	
Financial Management Services (FMS) Total:							6197862.00
Financial Management Services (FMS)		1 month	3300	11.00	170.74	6197862.00	
Children's Integrated Community Supports (CHICS) Total:							517140.00
Children's Integrated Community Supports (CHICS)		15 minutes	85	3900.00	1.56	517140.00	
Enhanced Care Service Total:							3931965.00
Enhanced Care Service		6-12 hours	150	230.00	113.97	3931965.00	
Home and Environmental Modification Services (HEMS) Total:							130680.00
Home and Environmental Modification Services (HEMS)		1 purchase	8	1.00	16335.00	130680.00	
Medical Alert Rental Total:							41477.00
Medical Alert Rental		1 month	190	10.00	21.83	41477.00	
Specialized Medical Care							8618625.00
GRAND TOTAL:						614853412.30	
Total: Services included in capitation:						614853412.30	
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:						9895	
Factor D (Divide total by number of participants):						62137.79	
Services included in capitation:						62137.79	
Services not included in capitation:							
Average Length of Stay on the Waiver:							354

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Specialized Medical Care (RN)	<input type="checkbox"/>	15 minutes	33	4500.00	11.75	1744875.00	
Specialized Medical Care (LPN)	<input type="checkbox"/>	15 minutes	78	7500.00	11.75	6873750.00	
Specialized Medical Equipment and Supplies (SMES) Total:							21780.00
Specialized Medical Equipment and Supplies (SMES)	<input type="checkbox"/>	1 purchase	33	1.00	660.00	21780.00	
Vehicle Modification Services (VMS) Total:							65340.00
Vehicle Modification Services (VMS)	<input type="checkbox"/>	1 purchase	5	1.00	13068.00	65340.00	
Wellness Monitoring Total:							165587.50
Wellness Monitoring	<input type="checkbox"/>	1 visit	650	5.00	50.95	165587.50	
GRAND TOTAL:						614853412.30	
<i>Total: Services included in capitation:</i>						614853412.30	
<i>Total: Services not included in capitation:</i>							
<i>Total Estimated Unduplicated Participants:</i>						9895	
<i>Factor D (Divide total by number of participants):</i>						62137.79	
<i>Services included in capitation:</i>						62137.79	
<i>Services not included in capitation:</i>							
<i>Average Length of Stay on the Waiver:</i>							354

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Supports Total:							165357360.00
Day Supports		15 minutes	6540	4200.00	6.02	165357360.00	
Overnight Respite Care Total:							478674.00
Overnight Respite Care		1 day	200	21.00	113.97	478674.00	
Personal Care Service (PCS) Total:							93687800.00
Personal Care Services - Self-Directed		15 minutes	3300	6400.00	4.14	87436800.00	
Personal Care Services - Agency-Directed		15 minutes	400	3325.00	4.70	6251000.00	
Residential Supports Total:							334555146.80
Residential Supports		1 day	5462	335.00	182.84	334555146.80	
Supported Employment (SE) Total:							1083975.00
Supported Employment (SE)		15 minutes	250	970.00	4.47	1083975.00	
Financial Management Services (FMS) Total:							6197862.00
Financial Management Services (FMS)		1 month	3300	11.00	170.74	6197862.00	
Children's Integrated Community Supports (CHICS) Total:							517140.00
Children's Integrated Community Supports (CHICS)		15 minutes	85	3900.00	1.56	517140.00	
Enhanced Care Service Total:							3931965.00
Enhanced Care Service		6-12 hours	150	230.00	113.97	3931965.00	
Home and Environmental Modification Services (HEMS)							130680.00
GRAND TOTAL:							614853412.30
Total: Services included in capitation:							614853412.30
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							9895
Factor D (Divide total by number of participants):							62137.79
Services included in capitation:							62137.79
Services not included in capitation:							
Average Length of Stay on the Waiver:							354

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Home and Environmental Modification Services (HEMS)	<input type="checkbox"/>	1 purchase	8	1.00	16335.00	130680.00	
Medical Alert Rental Total:							41477.00
Medical Alert Rental	<input type="checkbox"/>	1 month	190	10.00	21.83	41477.00	
Specialized Medical Care Total:							8618625.00
Specialized Medical Care (RN)	<input type="checkbox"/>	15 minutes	33	4500.00	11.75	1744875.00	
Specialized Medical Care (LPN)	<input type="checkbox"/>	15 minutes	78	7500.00	11.75	6873750.00	
Specialized Medical Equipment and Supplies (SMES) Total:							21780.00
Specialized Medical Equipment and Supplies (SMES)	<input type="checkbox"/>	1 purchase	33	1.00	660.00	21780.00	
Vehicle Modification Services (VMS) Total:							65340.00
Vehicle Modification Services (VMS)	<input type="checkbox"/>	1 purchase	5	1.00	13068.00	65340.00	
Wellness Monitoring Total:							165587.50
Wellness Monitoring	<input type="checkbox"/>	1 visit	650	5.00	50.95	165587.50	
GRAND TOTAL:							614853412.30
Total: Services included in capitation:							614853412.30
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							9895
Factor D (Divide total by number of participants):							62137.79
Services included in capitation:							62137.79
Services not included in capitation:							
Average Length of Stay on the Waiver:							354

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Supports Total:							165357360.00
Day Supports		15 minutes	6540	4200.00	6.02	165357360.00	
Overnight Respite Care Total:							478674.00
Overnight Respite Care		1 day	200	21.00	113.97	478674.00	
Personal Care Service (PCS) Total:							93687800.00
Personal Care Services - Self-Directed		15 minutes	3300	6400.00	4.14	87436800.00	
Personal Care Services - Agency-Directed		15 minutes	400	3325.00	4.70	6251000.00	
Residential Supports Total:							334555146.80
Residential Supports		1 day	5462	335.00	182.84	334555146.80	
Supported Employment (SE) Total:							1083975.00
Supported Employment (SE)		15 minutes	250	970.00	4.47	1083975.00	
Financial Management Services (FMS) Total:							6197862.00
Financial Management Services (FMS)		1 month	3300	11.00	170.74	6197862.00	
Children's Integrated Community Supports (CHICS) Total:							517140.00
Children's Integrated Community Supports (CHICS)		15 minutes	85	3900.00	1.56	517140.00	
Enhanced Care Service Total:							3931965.00
Enhanced Care Service		6-12 hours	150	230.00	113.97	3931965.00	
Home and							130680.00
GRAND TOTAL:							614853412.30
<i>Total: Services included in capitation:</i>							614853412.30
<i>Total: Services not included in capitation:</i>							
<i>Total Estimated Unduplicated Participants:</i>							9895
<i>Factor D (Divide total by number of participants):</i>							62137.79
<i>Services included in capitation:</i>							62137.79
<i>Services not included in capitation:</i>							
<i>Average Length of Stay on the Waiver:</i>							354

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Modification Services (HEMS) Total:							
Home and Environmental Modification Services (HEMS)		1 purchase	8	1.00	16335.00	130680.00	
Medical Alert Rental Total:							41477.00
Medical Alert Rental		1 month	190	10.00	21.83	41477.00	
Specialized Medical Care Total:							8618625.00
Specialized Medical Care (RN)		15 minutes	33	4500.00	11.75	1744875.00	
Specialized Medical Care (LPN)		15 minutes	78	7500.00	11.75	6873750.00	
Specialized Medical Equipment and Supplies (SMES) Total:							21780.00
Specialized Medical Equipment and Supplies (SMES)		1 purchase	33	1.00	660.00	21780.00	
Vehicle Modification Services (VMS) Total:							65340.00
Vehicle Modification Services (VMS)		1 purchase	5	1.00	13068.00	65340.00	
Wellness Monitoring Total:							165587.50
Wellness Monitoring		1 visit	650	5.00	50.95	165587.50	
GRAND TOTAL:							614853412.30
Total: Services included in capitation:							614853412.30
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							9895
Factor D (Divide total by number of participants):							62137.79
Services included in capitation:							62137.79
Services not included in capitation:							
Average Length of Stay on the Waiver:							354

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User,

and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Supports Total:							165357360.00
Day Supports	<input type="checkbox"/>	15 minutes	6540	4200.00	6.02	165357360.00	
Overnight Respite Care Total:							478674.00
Overnight Respite Care	<input type="checkbox"/>	1 day	200	21.00	113.97	478674.00	
Personal Care Service (PCS) Total:							93687800.00
Personal Care Services - Self-Directed	<input type="checkbox"/>	15 minutes	3300	6400.00	4.14	87436800.00	
Personal Care Services - Agency-Directed	<input type="checkbox"/>	15 minutes	400	3325.00	4.70	6251000.00	
Residential Supports Total:							334555146.80
Residential Supports	<input type="checkbox"/>	1 day	5462	335.00	182.84	334555146.80	
Supported Employment (SE) Total:							1083975.00
Supported Employment (SE)	<input type="checkbox"/>	15 minutes	250	970.00	4.47	1083975.00	
Financial Management Services (FMS) Total:							6197862.00
Financial Management Services (FMS)	<input type="checkbox"/>	1 month	3300	11.00	170.74	6197862.00	
Children's Integrated Community Supports (CHICS) Total:							517140.00
Children's Integrated Community Supports (CHICS)	<input type="checkbox"/>	15 minutes	85	3900.00	1.56	517140.00	
Enhanced Care Service Total:							3931965.00
GRAND TOTAL:							614853412.30
Total: Services included in capitation:							614853412.30
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							9895
Factor D (Divide total by number of participants):							62137.79
Services included in capitation:							62137.79
Services not included in capitation:							
Average Length of Stay on the Waiver:							354

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Enhanced Care Service		6-12 hours	150	230.00	113.97	3931965.00	
Home and Environmental Modification Services (HEMS) Total:							130680.00
Home and Environmental Modification Services (HEMS)		1 purchase	8	1.00	16335.00	130680.00	
Medical Alert Rental Total:							41477.00
Medical Alert Rental		1 month	190	10.00	21.83	41477.00	
Specialized Medical Care Total:							8618625.00
Specialized Medical Care (RN)		15 minutes	33	4500.00	11.75	1744875.00	
Specialized Medical Care (LPN)		15 minutes	78	7500.00	11.75	6873750.00	
Specialized Medical Equipment and Supplies (SMES) Total:							21780.00
Specialized Medical Equipment and Supplies (SMES)		1 purchase	33	1.00	660.00	21780.00	
Vehicle Modification Services (VMS) Total:							65340.00
Vehicle Modification Services (VMS)		1 purchase	5	1.00	13068.00	65340.00	
Wellness Monitoring Total:							165587.50
Wellness Monitoring		1 visit	650	5.00	50.95	165587.50	
GRAND TOTAL:							614853412.30
Total: Services included in capitation:							614853412.30
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							9895
Factor D (Divide total by number of participants):							62137.79
Services included in capitation:							62137.79
Services not included in capitation:							
Average Length of Stay on the Waiver:							354