# 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 waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

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

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

## 1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

Kansas recently amended the waiver application to include the new quality measures in order to comply with CMS requirements. Kansas is submitting a renewal of HCBS/FE program requesting CMS approval for modification to the brief description and the following changes to the program:

1) KDADS has developed a transition plan for the HCBS/FE settings that will assess and ensure Kansas provider settings meet the requirements of the HCBS Final Setting Rule within 5 years.

2) Kansas has contracted with Kansas University (KU) to evaluate the current assessment instrument in comparison to other States to identify an assessment instrument with demonstrated reliability and validity. The purpose of this contract is to develop a standardized eligibility assessment to assess level of care eligibility for all HCBS populations.

# 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*):

Home and Community Based Services for the Frail Elderly

**C. Type of Request: renewal**

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

○ **3 years** ◉ **5 years**

**Original Base Waiver Number: KS.0303**
**Waiver Number:KS.0303.R04.00**
**Draft ID: KS.006.04.00**

**D. Type of Waiver** *(select only one):*

Regular Waiver

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

01/01/15

**Approved Effective Date: 01/01/15**

## 1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

- ○ **Hospital as defined in 42 CFR §440.10**
  If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:
- ○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☑ **Nursing Facility**

Select applicable level of care

- ◉ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**
  If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
- ○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

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

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

## 1. Request Information (3 of 3)

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

Select one:

- ○ **Not applicable**
- ◉ **Applicable**

Check the applicable authority or authorities:

- ☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**
- ☐ **Waiver(s) authorized under §1915(b) of the Act.**

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

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

  - ☐ **§1915(b)(1) (mandated enrollment to managed care)**
  - ☐ **§1915(b)(2) (central broker)**
  - ☐ **§1915(b)(3) (employ cost savings to furnish additional services)**
  - ☐ **§1915(b)(4) (selective contracting/limit number of providers)**
- ☐ **A program operated under §1932(a) of the Act.**

  Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:
- ☐ **A program authorized under §1915(i) of the Act.**
- ☐ **A program authorized under §1915(j) of the Act.**
- ☑ **A program authorized under §1115 of the Act.**

  Specify the program:

  KanCare 1115 Demonstration Project

**H. Dual Eligiblity for Medicaid and Medicare.**

Check if applicable:

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

## 2. Brief Waiver Description

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

The HCBS/FE waiver provides community based services an alternative to nursing facility care, to promote independence in the community setting and to ensure residency in the most integrated environment. FE services are available to individuals who are at least 65 years of age and who are financially eligible for Medicaid. Individuals must also meet the minimum FE threshold score on a functional assessment. KDADS has contracted with one provider who is responsible for conducting Level of Care determinations acting as the State's designee. Participants are annually reassessed by the Functinal Eligible Contractor to determine if they continue to meet the level of care.

Services available through the FE waiver are: Financial Management Services, Adult Day Care, Assistive Technology, Attendant Care Services (provider agency directed or self-directed), Comprehensive Support (provider agency directed or self-directed), Home Tele health, Medication Reminder, Nursing Evaluation Visit, Oral Health Services, Personal Emergency Response, Sleep Cycle Support--Self Directed, and Wellness Monitoring.

## 3. Components of the Waiver Request

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

**A. Waiver Administration and Operation. Appendix A** specifies the administrative and operational structure of this waiver.

**B. Participant Access and Eligibility. Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

**C. Participant Services. Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

**D. Participant-Centered Service Planning and Delivery. Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

**E. Participant-Direction of Services.** When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- ◉ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ○ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

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

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

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

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

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

## 4. Waiver(s) Requested

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

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

- ○ **Not Applicable**
- ○ **No**
- ◉ **Yes**

**C. Statewideness.** Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- ◉ **No**
- ○ **Yes**

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

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals

who reside in the following geographic areas or political subdivisions of the State.
*Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

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

## 5. Assurances

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

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

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

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

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

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

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

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

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

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

**H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be

consistent with a data collection plan designed by CMS.

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

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

## 6. Additional Requirements

***Note: Item 6-I must be completed.***

A. **Service Plan**. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. **Inpatients**. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. **Room and Board**. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. **Access to Services**. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. **Free Choice of Provider**. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. **FFP Limitation**. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. **Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. **Quality Improvement**. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. **Public Input.** Describe how the State secures public input into the development of the waiver:

Tribal notices were sent on 01/17/14 to inform tribal leaders of intent to renew the FE waiver. Public sessions occured in February and March 2014.

Public/Stakeholder Input was received February 18, 21, 24, 25, and 28. Public/Stakeholder Input was received March 7,12,14, 21, 2014.

KDADS conducted public input sessions during November 2014 to present HCBS-FE program proposed changes, specific transition plans and the renewal. KDADS sought public input at regional in-person meetings, via teleconference and other non-electronic formats. KDADS received several comments/ feedback a few

**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:** Graff-Hendrixson

**First Name:** Bobbie

**Title:** Senior Manager, Contracts, State Plans and Regulations

**Agency:** Kansas Department of Health and Environment

**Address:** 900 SW Jackson Street

**Address 2:** Suite 900N

**City:** Topeka

**State:** **Kansas**

**Zip:** 66612-1220

**Phone:** (785) 296-0149 **Ext:** ☐ **TTY**

**Fax:** (785) 296-4813

**E-mail:** BGraff-Hendrixson@kdheks.gov

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

**Last Name:** Leistra

**First Name:**

Laura

**Title:**

FE Program Manager

**Agency:**

Kansas Department for Aging and Disability Services

**Address:**

503 S. Kansas Ave

**Address 2:**

**City:**

Topeka

**State:** **Kansas**

**Zip:**

66603

**Phone:**

(785) 296-4980 **Ext:** ☐ **TTY**

**Fax:**

(785) 296-0256

**E-mail:**

Laura.Leistra@kdads.ks.gov

## 8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

**Signature:** Bobbie Graff-Hendrixson

State Medicaid Director or Designee

**Submission Date:** Aug 18, 2015

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

**Last Name:**

Mosier

**First Name:**

Susan

**Title:**

M.D., Medicaid Director, Director Division of Health Care Finance

**Agency:**

Kansas Dept of Health and Environment/Division of Health Care Finance

**Address:**

Landon State Office Building

**Address 2:**

900 SW Jackson, Suite 900

**City:**

Topeka

**State:** **Kansas**

**Zip:**

66612

**Phone:**

(785) 296-3981 **Ext:** ☐ **TTY**

**Fax:**

(785) 296-4813

**E-mail:**

smosier@kdheks.gov

## Attachments

**Attachment #1: Transition Plan**

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

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

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

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

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

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

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

*Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to*

*amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.*

The new Home and Community Based Services (HCBS) Settings Rule from the Centers for Medicare and Medicaid Services (CMS) applies to all programs that provide HCBS. In Kansas, this rule will apply to all settings where HCBS services are provided, HCBS-FE services are typically provided in the consumer's place of residence in the community.
This Transition Plan ensures the HCBS-FE program is in compliance with the new settings requirements and meets the expectations of CMS, prior to submission of the HCBS-FE Transition Plan. The final Transition Plan will incorporate changes relating to the comments and feedback from CMS, which will include the following:

- Summary of all public comments received for the HCBS-FE program relating to the proposed transition plan, including any revisions as a result of the public comments
- Inventory and description of all HCBS-FE settings

## Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

N/A

## 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/Community Services and Programs Commission

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 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

## Appendix A: Waiver Administration and Operation

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

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

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

The state's contracted assessor, Aging & Disability Resource Center (ADRC), conducts participant waiver assessment and level of care evaluation activities for current and potential consumers, as well as options counseling.

Managed Care Organizations conduct plan of care development and related service authorization, develop and review service plans, assist with utilization management, conduct provider credentialing, provider manual, and other provider guidance; and participate in the comprehensive state quality improvement strategy for the KanCare program including this waiver.

( ) **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:*

☐ **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:*

## Appendix A: Waiver Administration and Operation

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

administrative functions:

Kansas Department for Aging and Disability Services/ Community Services and Programs Commission

## 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, including both contracted entities/providers and the state's contracted KanCare managed care organizations, are monitored through the 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. All functions delegated to contracted entities will be included in the State's comprehensive quality strategy review processes. A key component of that monitoring and review process will be the interagency monitoring team, which will include HCBS waiver management staff from KDADS. In addition, the SSMA and the State operating agency will continue to operate collaboratively under an interagency agreement, as addressed in part A.2.b above, and that agreement will including oversight and monitoring of all HCBS programs and the KanCare MCOs and independent assessment contractors.

## 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 |
|---|---|---|---|
| **Participant waiver enrollment** | ☑ | ☑ | ☑ |
| **Waiver enrollment managed against approved limits** | ☑ | ☑ | ☑ |
| **Waiver expenditures managed against approved levels** | ☑ | ☑ | ☐ |
| **Level of care evaluation** | ☑ | ☑ | ☑ |
| **Review of Participant service plans** | ☑ | ☑ | ☑ |
| **Prior authorization of waiver services** | ☑ | ☑ | ☑ |
| **Utilization management** | ☑ | ☑ | ☑ |
| **Qualified provider enrollment** | ☑ | ☑ | ☑ |
| **Execution of Medicaid provider agreements** | ☑ | ☐ | ☐ |
| **Establishment of a statewide rate methodology** | ☑ | ☑ | ☐ |
| **Rules, policies, procedures and information development governing the waiver program** | ☑ | ☑ | ☑ |
| **Quality assurance and quality improvement activities** | ☑ | ☑ | ☑ |

## Appendix A: Waiver Administration and Operation

### Quality Improvement: Administrative Authority of the Single State Medicaid Agency

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's 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 Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports N=Number of Long-Term Care meetings that were represented by the program managers through in person attendance or written reports D=Number of Long-Term Care meetings**

**Data Source** (Select one):
**Meeting minutes**
If 'Other' is selected, specify:

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

**Performance Measure:**
**Number and percent of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency N=Number of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the state Medicaid Agency D=Number of Quality Review reports**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Quality Review 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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of waiver amendments and renewals reviewed and approved by the State Medicaid Agency prior to submission to CMS by the State Medicaid Agency N=Number of waiver amendments and renewals and approved by the State Medicaid Agency prior to submission to CMS D=Total number of waiver amendments and renewals**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Number of waiver amendments and renewals**

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

| | | |
|---|---|---|
| | ☐ **Other**<br>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**<br>Specify: | ☑ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency N=Number of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency D= Number of waiver policy changes implemented by the Operation Agency**

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

| **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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |

| | | |
|---|---|---|
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☑ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

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

Kansas Department of Health and Environment, Division of Health Care Finance (KDHE), the single state Medicaid agency, and Kansas Department for Aging and Disability Services (KDADS) work together to develop state operating agency priority identification regarding all waiver assurances and minimum standards/basic assurances. The state agencies work in partnership with participants, advocacy organizations, provider groups and other interested stakeholders to monitor the state quality strategy and performance standards and discuss priorities for remediation and improvement. The state quality improvement strategy includes protocols to review cross-service system data to identify trends and opportunities for improvement related to all Kansas waivers, policy and procedure development and systems change initiatives.
Data gathered by KDADS Regional Staff during the Quality Survey Process is compiled quarterly for evaluation and trending to identify areas for improvement. Upon completion of identified areas of improvement this information is compiled into reports and shared both internally and externally, including with KDHE. 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

**b. Methods for Remediation/Fixing Individual Problems**

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

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

**ii. Remediation Data Aggregation**

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

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| | |

| | |
|---|---|
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**

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

◉ **No**

○ **Yes**

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

## Appendix B: Participant Access and Eligibility

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

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

| Target Group | Included | Target SubGroup | Minimum Age | Maximum Age | |
|---|---|---|---|---|---|
| | | | | Maximum Age Limit | No Maximum Age Limit |
| ☑ **Aged or Disabled, or Both - General** | | | | | |
| | ☑ | **Aged** | 65 | | ☑ |
| | ☐ | **Disabled (Physical)** | | | |
| | ☐ | **Disabled (Other)** | | | |
| ☐ **Aged or Disabled, or Both - Specific Recognized Subgroups** | | | | | |
| | ☐ | **Brain Injury** | | | ☐ |
| | ☐ | **HIV/AIDS** | | | ☐ |
| | ☐ | **Medically Fragile** | | | ☐ |
| | ☐ | **Technology Dependent** | | | ☐ |
| ☐ **Intellectual Disability or Developmental Disability, or Both** | | | | | |
| | ☐ | **Autism** | | | ☐ |
| | ☐ | **Developmental Disability** | | | ☐ |
| | ☐ | **Intellectual Disability** | | | ☐ |
| ☐ **Mental Illness** | | | | | |
| | ☐ | **Mental Illness** | | | |
| | ☐ | **Serious Emotional Disturbance** | | | |

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

N/A

**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:*

## Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

☐ **Other safeguard(s)**

Specify:

## Appendix B: Participant Access and Eligibility

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

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

**Table: B-3-a**

| Waiver Year | Unduplicated Number of Participants |
|---|---|
| **Year 1** | 7038 |
| **Year 2** | 7179 |
| **Year 3** | 7322 |
| **Year 4** | 7469 |
| **Year 5** | 7618 |

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

- (●) **The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- ( ) **The State limits the number of participants that it serves at any point in time during a waiver year.**

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

**Table: B-3-b**

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

# Appendix B: Participant Access and Eligibility

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

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

- ( ) **Not applicable. The state does not reserve capacity.**
- (●) **The State reserves capacity for the following purpose(s).**

Purpose(s) the State reserves capacity for:

| Purposes | |
|---|---|
| **Military Inclusion** | |
| **Temporary Institutional Stay** | |
| **Money Follows the Person (MFP)** | |

## 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 who have been determined program eligible may bypass waitlist upon approval by KDADS. In the event Kansas instituted a waitlist, individuals who have been determined to meet the established FE waiver criteria will be allowed to bypass the waitlist and access services.

**Describe how the amount of reserved capacity was determined:**

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

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

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

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (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 enters into an institution such as hospitals, ICF/ID or nursing facilities for the purpose of seeking treatment for acute, habilitative or rehabilitative conditions on a temporary basis less than 90 days. Temporary stay is defined as a stay that includes the month of admission and two months following admission. Consumers that remain in the institution following the two month allotment will be terminated from the HCBS program. The consumer can choose to reapply for services at a later date and will be reinstated if the consumer meets program eligibility requirements or placed on a waiting list if applicable.

**Describe how the amount of reserved capacity was determined:**

This amount is a projected reserved capacity.

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

| Waiver Year | Capacity Reserved |
|---|---|
| Year 1 | 150 |
| Year 2 | 150 |
| Year 3 | 150 |

| | |
|---|---|
| Year 4 | 150 |
| Year 5 | 150 |

## 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):*

Money Follows the Person (MFP)

**Purpose** *(describe):*

The State reserves capacity for individuals transitioning from the MFP grant program to the HCBS-FE waiver. These individuals are moved onto the waiver immediately following the expiration of their MFP grant benefits.

In addition: State waiver appropriations historically have determined the number of individuals that can be served in the waiver. Funding for slots will continue to be appropriated separately for each waiver. To the extent annual appropriations remain constant or increase as savings from KanCare are realized, the State intends to increase the number of individuals served and reserves the ability to amend the waiver accordingly.

**Describe how the amount of reserved capacity was determined:**

MFP reserve capacity is based upon historial experience as to people who have chosen to enter the MFP program and anticipated related transitions.

**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 |
| Year 3 | 50 |
| Year 4 | 50 |
| Year 5 | 50 |

## 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:

To be eligible for HCBS-FE waiver services, participants (a) must be 65 years of age (b) meet the Medicaid long term care threshold; and (c) be determined functionally eligible for HCBS/FE waiver services according to the state approved HCBS/FE Functional Eligibility Instrument (FEI) and threshold guide level of care score (K.A.R. 30-5-305; K.A.R. 30-5-309).
Entry into the waiver is based on a first-come, first-served basis for applicants determined eligible. In the event there is a waiting list, entry is based on the time and date the assessment is completed. Responsibility for managing the waiting list remains with the State (KDHE and KDADS).
Participants may supersede the waiting list process if they fall into one of the following groups:
- Participants transferring directly from another HCBS waiver;

## Appendix B: Participant Access and Eligibility

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

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

## Appendix B: Participant Access and Eligibility

### B-4: Eligibility Groups Served in the Waiver

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

- ○ **§1634 State**
- ◉ **SSI Criteria State**
- ○ **209(b) State**

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

- ◉ **No**
- ○ **Yes**

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

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

- ☐ **Low income families with children as provided in §1931 of the Act**
- ☑ **SSI recipients**
- ☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- ☐ **Optional State supplement recipients**
- ☐ **Optional categorically needy aged and/or disabled individuals who have income at:**

*Select one*:

- ○ **100% of the Federal poverty level (FPL)**
- ○ **% of FPL, which is lower than 100% of FPL.**

Specify percentage: ____

- ☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- ☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- ☐ **Medically needy in 209(b) States (42 CFR §435.330)**
- ☑ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- ☑ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

*Specify:*

Parents and other caretaker relatives (42 CFR 435.110)

***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 spenddown 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 five-year period beginning January 1, 2014, 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 December 31, 2018.*

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

Operationally, the State continues to calculate patient liability, or member Share of Cost, and providers continue to be responsible for collecting it. In practice, this means the State reduces capitation payments by the individual Share of Cost amounts. The reduction is passed from the Managed Care Organization (MCO) to the provider in the form of reduced reimbursement, and the provider is responsible for collecting the difference.

The dollar amount for the allowance is $727. Excess income will only be applied to the cost of 1915(c) waiver services.

**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: 727 If this amount changes, this item will be revised

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

  *Specify formula:*

- ○ **Other**

  *Specify:*

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

Select one:

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

*Explanation of difference:*

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

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

Select one:

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

## Appendix B: Participant Access and Eligibility

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

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

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

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

## Appendix B: Participant Access and Eligibility

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

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

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

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

## Appendix B: Participant Access and Eligibility

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

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

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

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

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

## Appendix B: Participant Access and Eligibility

### B-6: Evaluation/Reevaluation of Level of Care

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

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

**i. Minimum number of services.**

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

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

- (●) **The provision of waiver services at least monthly**
- ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

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

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

- ( ) **Directly by the Medicaid agency**
- ( ) **By the operating agency specified in Appendix A**
- ( ) **By an entity under contract with the Medicaid agency.**

*Specify the entity:*

- (•) **Other**

*Specify:*

State contracted assessors "Aging and Disablity Resource Center (ADRC)" contracting with Kansas is responsible for performing the evaluation and reevaluation for level of care determination as indicated in appendix A of this application.

**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:

Qualifications of functional contractor LOC assessors:

Four year degree from an accredited college or university with a major in gerontology, nursing, health, social work, counseling, human development, family studies, or related area as defined by KDADS; or a Registered Nurse license to practice in the state of Kansas. The contractor must verify experience, education and certification requirements are met for assessors identified in 2.7.3.A2-4. The contractor must maintain these records for five (5) years following termination of employment.

**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 LOC instrument is also known as the FEI. The criteria to determine a participant's LOC is as follows:

- Activities of Daily Living (ADLs)
- Instrumental Activities of Daily Living (IADLs)
- Cognition
- Risk Factors

**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 LOC criteria utilized for initial assessments of HCBS/FE waiver applicants and reassessments (to be done at least annually) of waiver service participants is the LOC same criteria utilized by Nursing Facilities. Both applicants and participants must meet the Medicaid Long Term Care Threshold score based on an assessment completed with the FEI. The LOC assessment and reassessment process is conducted by a contracted qualified staff member. Information used to determine scores and other eligibility criteria can come from a variety of sources. The participant is the primary source of information. The contractor uses interview techniques that are considerate of any limitations the participant might have with hearing, eyesight, cognition, etc. Family members and other individuals who might have relevant information about the participant can also be interviewed. The contractor staff may also use clinical records, if available, and/or discuss the participant's status with the appropriate medical professional.

**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):*

Timely re-evaluations are a component part of the state's contract with the ARDC. Both expectations and guidelines are specified in the waiver program's policies and procedures, which the contracted assessors must follow. Assurance is provided through ongoing contract monitoring and review, and quality reviews conducted by state or MCO staff.

State contracted assessors have access to current lists of re-evaluations due on the KDADS system of record. State contracted assessors can generate a reevaluation list on a routine or as needed basis.

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:

Written and/or electronically retrievable documentation of all evaluations and reevaluations is maintained by the contractor. The state's contractor is using the state's KAMIS data base and the State's Medicaid Management Information System (MMIS).

## Appendix B: Evaluation/Reevaluation of Level of Care

### Quality Improvement: Level of Care

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

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

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

i. **Sub-Assurances:**

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

**Performance Measures**

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

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

**Performance Measure:**
**Number and percent of waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services N=Number of waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services D=Total number of enrolled waiver participants**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Operating Agency's data systems and Managed Care Organizations (MCOs) encounter data**

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

| | | |
|---|---|---|
| | | 95% |
| ☑ **Other**<br>Specify:<br>Contracted assessors and Managed Care Organizations (MCOs) | ☑ **Annually** | ☑ **Stratified**<br>Describe Group:<br>Proportionate by MCO |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify:<br>Contracted assessors participtae in analysis of this measure's results as determined by the State operating agency | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

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

**Performance Measures**

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

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

**Performance Measure:**
**Number and percent of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care determination N=Number of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care determination D=Number of waiver participants who received Level of Care redeterminations**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Operating agency's data systems: "Kansas Assessment Management Information (KAMIS) System or its related web applications"**

| **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**<br>Confidence Interval =<br>95% |
| ☑ **Other**<br>Specify:<br>Contracted assessors | ☐ **Annually** | ☑ **Stratified**<br>Describe Group:<br>Proportionate by MCO |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify:<br>Contracted assessors participate in analysis of this measure's results as determined by the State operating agency | ☑ **Annually** |

| | |
|---|---|
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

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

**Performance Measures**

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

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

**Performance Measure:**
**Number and percent of initial Level of Care (LOC) determinations made where the LOC criteria was accurately applied N=Number of initial Level of Care (LOC) determinations made where the LCO criteria was accurately applied D=Number of initial Level of Care determinations**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Record reviews**

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval =<br>95% |
| ☑ **Other**<br>Specify:<br>Contracted assessors | ☐ **Annually** | ☑ **Stratified**<br>Describe Group:<br>Proportionate by MCO |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify:<br>Contracted assessors participate in analysis of this measure's results as determined by the State operating agency | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of initial Level of Care (LOC) determinations made by a qualified assessor N=Number of initial Level Of Care (LOC)determinations made by a qualified assessor D=Number of initial Level of Care determinations**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Assessor and assessment records**

| **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**<br>Confidence Interval = |
| ☑ **Other**<br>Specify:<br>Contracted assessors | ☑ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |

| | | |
|---|---|---|
| | | |
| | ☐ **Other**<br>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**<br>Specify:<br>Contracted assessors participate in analysis of this measure's results as determined by the State operating agency | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of waiver participants whose Level of Care (LOC) determinations used the state's approved screening tool N=Number of waiver participants whose Level of Care determinations used the approved screening tool D=Number of waiver participants who had a Level of Care determination**

**Data Source** (Select one):
**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**<br>Confidence Interval =<br>95% |
| ☑ **Other**<br>Specify: | ☐ **Annually** | ☑ **Stratified**<br>Describe Group: |

| | | |
|---|---|---|
| Contracted assessors | | Proportionate by MCO |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☑ **Other** Specify: Contracted assessors participate in analysis of this measure's results as determined by the State operating agency | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

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

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

**b. Methods for Remediation/Fixing Individual Problems**

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

These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through a state interagency monitoring team, which includes program managers, contract managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

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

**ii. Remediation Data Aggregation**

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

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

| | |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☑ **Other**<br>Specify:<br>KanCare MCOs participate in analysis | ☐ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

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

- (●) **No**
- ( ) **Yes**

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

## 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).

During the plan of care development process, the KanCare MCO selected by the participant informs eligible participants, or their legal representatives, of feasible alternatives for long-term care, and documents their choice of either institutional or home and community-based waiver services utilizing the HCBS-FE Waiver Consumer Choice 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.

HCBS/FE Waiver Consumer Choice forms are documented and maintained by the participant's chosen KanCare MCO in the participant's case file.

## 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 (LEPP), 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 LEPP. In order to comply with federal requirements that individuals receive equal access to services provided by KDADS and to determine the kinds of resources necessary to assist staff in ensuring meaningful communication with LEPP, states are required to capture language preference information. This information is captured in the demographic section of the FEI 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

## 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 | | |
|---|---|---|---|
| **Supports for Participant Direction** | **Financial Management Services** | | |
| **Other Service** | **Adult Day Care** | | |
| **Other Service** | **Assistive Technology** | | |
| **Other Service** | **Comprehensive Support - Provider Directed** | | |
| **Other Service** | **Comprehensive Support - Self-Directed** | | |
| **Other Service** | **Home Telehealth** | | |
| **Other Service** | **Medication Reminder** | | |
| **Other Service** | **Nursing Evaluation Visit** | | |
| **Other Service** | **Oral Health Services** | | |
| **Other Service** | **Personal Care Services - Provider Directed** | | |
| **Other Service** | **Personal Care Services - Self-Directed** | | |
| **Other Service** | **Personal Emergency Response** | | |
| **Other Service** | **Sleep Cycle Support - Self-Directed** | | |
| **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:**

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):**

**HCBS Taxonomy:**

**Category 1:**

12 Services Supporting Self-Direction
13 Participant Training

**Sub-Category 1:**

12010 financial management services in support of self-direction
12020 information and assistance in support of self-direction

**Category 2:**

12 Services Supporting Self-Direction
13 Participant Training

**Sub-Category 2:**

12010 financial management services in support of self-direction
12020 information and assistance in support of self-direction

**Category 3:** 17 Other Services

**Sub-Category 3:**

**Category 4:** 17 Other Services

**Sub-Category 4:**

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

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

**Service Definition** *(Scope):*

Kansas is promoting true choice by making options available to the participant or responsible party by entering into an employment support with the Financial Management Services (FMS) provider and to work collaboratively with the FMS to ensure the receipt of quality, needed support services from direct support workers. The participant retains the primary responsibility as the common law employer. FMS service will be provided through a third party entity.

The MCO will ensure that persons seeking or receiving participant-directed services have been informed of the benefits and responsibilities of the participant-direction and provide the choice of FMS providers. The choice will be presented to the person initially at the time participant-direction is chosen and annually during his/her plan of care planning process, or at any time requested by the participant or the person directing services on behalf of the participant. The MCO is responsible for documenting the provider choice. In addition, The MCO will be responsible for informing the participant of the process for changing or

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

LIMITATIONS:
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.

**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 | Enrolled FMS Provider |

## Appendix C: Participant Services

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

**Service Type: Supports for Participant Direction**
**Service Name: Financial Management Services**

**Provider Category:**

Agency

**Provider Type:**

Enrolled FMS Provider

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*

Enrolled FMS providers will furnish Financial Management Services according to Kansas 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 submit a signed Provider Agreement to the State Operating Agency, KDADS, prior to enrollment 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 required financial audit. In addition, organizations are required to submit the following documents with the signed agreement:

- Community Developmental Disability Organization (CDDO) agreement (I/DD only)

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Kansas Department of Health and Environment (SSMA), KDADS-Quality Management Specialists will review and collect data to support whether the MCOs are assuring the FMS providers are complying with the qualifications as specified in the waiver.and KanCare MCOs are responsible for ensuring the FMS provider met the approved standards

**Frequency of Verification:**

This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.

## 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:**

Adult Day Care

**HCBS Taxonomy:**

**Category 1:**

04 Day Services
05 Nursing

**Sub-Category 1:**

04060 adult day services (social model)
04070 community integration

**Category 2:**

17 Other Services

**Sub-Category 2:**

**Category 3:**

17 Other Services

**Sub-Category 3:**

**Category 4:**

17 Other Services

**Sub-Category 4:**

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

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

**Service Definition** *(Scope):*

Service Definition
This service is designed to maintain optimal physical and social functioning for HCBS/FE participants. This service provides a balance of activities to meet the interrelated needs and interests (e.g., social, intellectual, cultural, economic, emotional, and physical) of HCBS/FE participants. This service shall not duplicate waiver services.
This service includes:
- Basic nursing care as delegated or provided by a licensed nurse and as identified in the service plan

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

Limitations
- Service may not be provided in the participant's own residence
- Participants living in an Assisted Living Facility, Residential Health Care Facility, or a Home Plus are not eligible for this service
- Service is limited to a maximum of two units of service per day, one or more days per week
- Registered nurse must be available on-call as needed

**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 | KDADS licensed free-standing Adult Day Care Facility, Nursing Facility, Assisted Living Facility, Residential Health Care Facility, and Home Plus |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Adult Day Care**

**Provider Category:**

Agency

**Provider Type:**

KDADS licensed free-standing Adult Day Care Facility, Nursing Facility, Assisted Living Facility, Residential Health Care Facility, and Home Plus

**Provider Qualifications**

**License** *(specify)*:

K.S.A. 39-923 et seq.
K.A.R. 26-41-203(b)
K.A.R. 26-42-203(b)
K.A.R. 26-43-101 et seq.
K.A.R. 28-39-160(b)

**Certificate** *(specify)*:

**Other Standard** *(specify)*:

K.A.R. 30-5-59 is the provider participation requirements for Medicaid which requires but not limited to: application to be submitted; specified credentials be maintained; notification of change of ownership; recordkeeping; accept payment in full, not charge customers for services covered by the program.

All standards, certifications and licenses that are required for the specific field through which service is provided including but not limited to: professional license / certification if required; adherence to KDADS's training and professional development requirements; maintenance of clear background as evidenced through background checks of: KBI, ADS CPS, Nurse Aid Registry, and Motor Vehicle screen

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs

**Frequency of Verification:**

This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.

# 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:**

Assistive Technology

**HCBS Taxonomy:**

**Category 1:**

14 Equipment, Technology, and Modifications
15 Non-Medical Transportation

**Sub-Category 1:**

14010 personal emergency response system (PERS)
14020 home and/or vehicle accessibility adaptations

**Category 2:**

17 Other Services

**Sub-Category 2:**

**Category 3:**

17 Other Services

**Sub-Category 3:**

**Category 4:**

17 Other Services

**Sub-Category 4:**

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

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

**Service Definition** *(Scope):*

Assistive technology consists of:
- Purchase of an item or piece of equipment that improves or assists with functional capabilities including, but not limited to, grab-bars, bath benches, toilet risers, and lift chairs; or
- Purchase and installation of home modifications that improve mobility including, but not limited to, ramps, widening of doorways, bathroom modifications, and railings.

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

LIMITATIONS:
- Assistive Technology is limited to the participant's assessed level of service need, as specified in the participant's Plan of Care, subject to an exception process established by the state. All participants are held to the same criteria when qualifying for an exception in accordance with the established KDADS policies and guidelines.

Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant.

**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 | Any business, agency, or company that furnishes assistive technology items or services |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Assistive Technology**

**Provider Category:**

Agency

**Provider Type:**

Any business, agency, or company that furnishes assistive technology items or services

**Provider Qualifications**

**License** *(specify):*

K.A.R. 129-5-108: "The Durable Medical Equiment [DME] shall be available to each beneficiary, with the following limitations: (1) The DME shall be the most econonomical to meet the beneficiary's need...(6) DME shall be covered for only the following types of beneficiaries: (A) Participants of the Kan Be Healthy program; (B) beneficiaries who require DME for life support; (C) beneficiaries who require DME for employment and; (D) beneficiaries who would require more expensive care if the DME was not provided."

**Certificate** *(specify):*

**Other Standard** *(specify):*

K.A.R. 30-5-59
Companies chosen to provide adaptations to housing structures must be licensed or certified by the county or city and must perform all work according to existing building codes. If the company is not licensed or certified, then a letter from the county or city must be provided stating licensure or certification is not required.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs

**Frequency of Verification:**

This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.

## 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:**

## Comprehensive Support - Provider Directed

**HCBS Taxonomy:**

**Category 1:**

08 Home-Based Services
09 Caregiver Support

**Sub-Category 1:**

08030 personal care
08040 companion

**Category 2:**

08 Home-Based Services
09 Caregiver Support

**Sub-Category 2:**

08010 home-based habilitation
08020 home health aide

**Category 3:**

17 Other Services

**Sub-Category 3:**

**Category 4:**

17 Other Services

**Sub-Category 4:**

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

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

**Service Definition** *(Scope):*

Comprehensive Support is one-on-one non-medical assistance, observation, and supervision, provided to a cognitively impaired adult to meet their health and welfare needs. The provision of comprehensive support does not entail hands-on nursing care; the primary focus is supportive supervision.

The support worker is present to supervise the participant and to assist with incidental care as needed, as opposed to attendant care which is task specific. Leisure activities (for example: read mail, books, and magazines or write letters) may also be provided.

Comprehensive Support is to be provided in the individual's choice of housing, including temporary arrangements. This service shall not duplicate other waiver services.

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

LIMITATIONS:

- Comprehensive Support is limited to the participant's assessed level of service need, as specified in the participant's Plan of Care, not to exceed twelve (12) hours per 24-hour time period, subject to an exception process established by the state. All participants are held to the same criteria when qualifying for an exception, in accordance with the established KDADS policies and guidelines.

Crisis exception criteria:

**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 | Medicare certified or KDHE licensed Home Health Agency |
| Agency | County Health Department |
| Agency | Entities not licensed by DCF, KDADS, or KDHE |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Comprehensive Support - Provider Directed**

**Provider Category:**

Agency

**Provider Type:**

Medicare certified or KDHE licensed Home Health Agency

**Provider Qualifications**

**License** *(specify):*

K.S.A. 65-5101 et seq.
K.A.R. 28-51-100 et seq.

**Certificate** *(specify):*

**Other Standard** *(specify):*

K.A.R. 30-5-59 is the provider participation requirements for Medicaid which requires but not limited to: application to be submitted; specified credentials be maintained; notification of change of ownership; recordkeeping; accept payment in full, not charge customers for services covered by the program.

All standards, certifications and licenses that are required for the specific field through which service is provided including but not limited to: professional license / certification if required; adherence to KDADS's training and professional development requirements; maintenance of clear background as evidenced through background checks of: KBI, APS CPS, Nurse Aid Registry, and Motor Vehicle screen

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.

**Frequency of Verification:**

This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Comprehensive Support - Provider Directed**

**Provider Category:**

Agency

**Provider Type:**

County Health Department

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*

K.S.A. 65-201 et seq.describes local health departments.
K.A.R. 30-5-59 is the provider participation requirements for Medicaid which requires but not limited to: application to be submitted; specified credentials be maintained; notification of change of ownership; recordkeeping; accept payment in full, not charge customers for services covered by the program.

All standards, certifications and licenses that are required for the specific field through which service is provided including but not limited to: professional license / certification if required; adherence to KDADS's training and professional development requirements; maintenance of

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.

**Frequency of Verification:**

This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Comprehensive Support - Provider Directed**

**Provider Category:**

Agency

**Provider Type:**

Entities not licensed by DCF, KDADS, or KDHE

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*

K.A.R. 30-5-59 is the provider participation requirements for Medicaid which requires but not limited to: application to be submitted; specified credentials be maintained; notification of change of ownership; recordkeeping; accept payment in full, not charge customers for services covered by the program.
Entities not licensed by DCF, KDADS, or KDHE must provide the following:
1) A certified copy of its Articles of Incorporation or Articles or Organization. If a corporation or limited liability company is organized in a jurisdiction outside the state of Kansas, the entity shall provide written proof that it is authorized to do business in the state of Kansas.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.

**Frequency of Verification:**

This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.

## 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:**

## Comprehensive Support - Self-Directed

**HCBS Taxonomy:**

**Category 1:**

08 Home-Based Services
09 Caregiver Support

**Sub-Category 1:**

08030 personal care
08040 companion

**Category 2:**

08 Home-Based Services
09 Caregiver Support

**Sub-Category 2:**

08010 home-based habilitation
08020 home health aide

**Category 3:**

17 Other Services

**Sub-Category 3:**

**Category 4:**

17 Other Services

**Sub-Category 4:**

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

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

**Service Definition** *(Scope):*

Comprehensive Support is one-on-one non-medical assistance, observation, and supervision, provided to a cognitively impaired adult to meet their health and welfare needs. The provision of comprehensive support does not entail hands-on nursing care; the primary focus is supportive supervision.

The direct support worker is present to supervise the participant and to assist with incidental care as needed, as opposed to attendant care which is task specific. Leisure activities (for example: read mail, books, and magazines or write letters) may also be provided.

Comprehensive Support is to be provided in the individual's choice of housing, including temporary arrangements. This service shall not duplicate other waiver services.

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

LIMITATIONS:

- Comprehensive Support is limited to the participant's assessed level of service need, as specified in the participant's Plan of Care, not to exceed twelve (12) hours per 24-hour time period, subject to an exception process established by the state. All participants are held to the same criteria when qualifying for an exception, in accordance with the established KDADS policies and guidelines.

Crisis exception criteria:

**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 | Enrolled FMS Provider |
| Individual | Individual Comprehensive Support Worker |

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Comprehensive Support - Self-Directed**

**Provider Category:**

Agency

**Provider Type:**

Enrolled FMS Provider

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*

Must be an enrolled Medicaid provider of Comprehensive Support - Self-Direct

1. Each potential Agency With Choice Financial Management Services (FMS) entity must complete and maintain in good standing:
a. KDADS Provider Agreement
i. Applications are available on the following website:

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Kansas Department of Health and Environment (SSMA), KDADS-Quality Management Specialists will review and collect data to support whether the MCOs are assuring the FMS providers are complying with the qualifications as specified in the waiver.and KanCare MCOs are responsible for ensuring the FMS provider met the approved standards

**Frequency of Verification:**

This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Comprehensive Support - Self-Directed**

**Provider Category:**

Individual

**Provider Type:**

Individual Comprehensive Support Worker

**Provider Qualifications**

**License** *(specify):*

N/A

**Certificate** *(specify):*

N/A

**Other Standard** *(specify):*

- Must sign an agreement with a Medicaid-enrolled Financial Management Services (FMS) provider;
- Must be at least eighteen years of age or older;
- Comprehensive Support Worker must have a permanent residence separate and apart from the participant.

All standards, certifications and licenses that are required for the specific field through which service is provided including but not limited to: professional license / certification if required; adherence to KDADS's training and professional development requirements; maintenance of

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.

**Frequency of Verification:**

This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.

## 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 Telehealth

**HCBS Taxonomy:**

**Category 1:**

11 Other Health and Therapeutic Services
12 Services Supporting Self-Direction
13 Participant Training

**Sub-Category 1:**

11030 medication assessment and/or management
11040 nutrition consultation
11050 physician services

**Category 2:**

11 Other Health and Therapeutic Services
12 Services Supporting Self-Direction
13 Participant Training

**Sub-Category 2:**

11030 medication assessment and/or management
11040 nutrition consultation
11050 physician services

**Category 3:**

17 Other Services

**Sub-Category 3:**

**Category 4:**

17 Other Services

**Sub-Category 4:**

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

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

**Service Definition** *(Scope):*

Home telehealth is a remote monitoring system provided to a participant that enables the participant to effectively manage one or more diseases and catch early signs of trouble so intervention can occur before the participant's health declines. The provision of home telehealth entails participant education specific to one or more diseases (e.g. COPD, CHF, Hypertension, or Diabetes), counseling, and nursing supervision.

Home telehealth automates disease management activities, and engages participants with personalized daily interactions and education to build or expand the participant's self-management behaviors. The service will enable telehealth providers, after determining the customer's progress, to motivate behavior changes through user-friendly technology, helping customers meet goals for improved compliance with diet, exercise, medication, medical treatments, and self-monitoring of conditions to lower healthcare costs.

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

LIMITATIONS:
• Registered Nurse (RN) or licensed practical nurse with RN supervision to set up/supervise/ provide customer counseling
• Customer must have a land line or wireless connection
• Installation required within 10 working days of approval
• Maximum of two installations per calendar year

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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 | County Health Department; Medicare certified or KDHE licensed Home Health Agency |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Home Telehealth**

**Provider Category:**

Agency

**Provider Type:**

County Health Department; Medicare certified or KDHE licensed Home Health Agency

**Provider Qualifications**

**License** *(specify)*:

K.S.A. 65-5101 et seq.
K.A.R. 28-51-100 et seq.

**Certificate** *(specify)*:

**Other Standard** *(specify)*:

K.S.A. 65-201 et seq.
K.A.R. 30-5-59
System equipment capable of monitoring customer vital signs daily including, at a minimum, heart rate, blood pressure, mean arterial pressure, weight, oxygen saturation, and temperature, and capable of asking the customer questions that are tailored to the customer's diagnosis. The provider and equipment must have needed language options – e.g. English/Spanish/Russian/Vietnamese.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.

**Frequency of Verification:**

This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.

## 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:**

Medication Reminder

**HCBS Taxonomy:**

**Category 1:**

11 Other Health and Therapeutic Services
12 Services Supporting Self-Direction

**Sub-Category 1:**

11030 medication assessment and/or management
11040 nutrition consultation

**Category 2:**

17 Other Services

**Sub-Category 2:**

**Category 3:**

17 Other Services

**Sub-Category 3:**

**Category 4:**

17 Other Services

**Sub-Category 4:**

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

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

**Service Definition** *(Scope)*:

Provides a scheduled reminder to a participant when it's time for him/her to take medications. The reminder may be a phone call, an automated recording, or an automated alarm, depending on the provider's system.

This service does not duplicate other waiver services.

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

LIMITATIONS:

- Maintenance of rental equipment is the responsibility of the provider.
- Repair/replacement of rental equipment is not covered.
- Rental, but not purchase, of this service is covered.
- This service is limited to those participants who live alone, or who are alone a significant portion of the day in residential settings, and have no regular caretaker for extended periods of time, and who otherwise require extensive routine supervision.

**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** | **Medication Reminder Co; Personal Emergency Response Co; Medicare certified or KDHE licensed Home Health Agency; KDHE** |

| | |
|---|---|
| | **licensed Hospital; and Emergency Medical Services** |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Medication Reminder**

**Provider Category:**

Agency

**Provider Type:**

Medication Reminder Co; Personal Emergency Response Co; Medicare certified or KDHE licensed Home Health Agency; KDHE licensed Hospital; and Emergency Medical Services

**Provider Qualifications**

**License** *(specify):*

K.S.A. 65-425 et seq.
K.S.A. 65-5101 et seq.
K.A.R. 28-34-2
K.A.R. 28-51-100 et seq.

**Certificate** *(specify):*

**Other Standard** *(specify):*

K.S.A. 65-6112 et seq.describes emergency medical services.
K.A.R. 30-5-59,is the provider participation requirements for Medicaid which requires but not limited to: application to be submitted; specified credentials be maintained; notification of change of ownership; recordkeeping; accept payment in full, not charge customers for services covered by the program.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.

**Frequency of Verification:**

This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.

## 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:**

Nursing Evaluation Visit

**HCBS Taxonomy:**

**Category 1:** **Sub-Category 1:**

11 Other Health and Therapeutic Services
12 Services Supporting Self-Direction

11010 health monitoring
11020 health assessment

**Category 2:**

17 Other Services

**Sub-Category 2:**

**Category 3:**

17 Other Services

**Sub-Category 3:**

**Category 4:**

17 Other Services

**Sub-Category 4:**

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

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

**Service Definition** *(Scope):*

A Nursing Evaluation Visit is different from the initial assessment that is used to develop the Plan of Care (POC). Nursing Evaluation Visit is a service provided only to participants that receive Level II Personal Care Services through a Home Health Agency, Assisted Living Facility, Residential Health Care Facility, or other licensed entity. Nursing Evaluation Visits are conducted by an RN employed by the provider of Level II Personal Care Services. During the Nursing Evaluation Visit, the RN determines which attendant may best meet the needs of the participant, and any special instructions/requests of the participant regarding delivery of services. This service includes an initial face-to-face evaluation visit by an RN, one time, per participant, per provider.

Personal Care Services - Level II services that require an initial Nursing Evaluation Visit are Health Maintenance Activities:

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

LIMITATIONS:

- A Nursing Evaluation Visit will need to be completed for a participant to access provider-directed Attendant Care Services Level II.
- If a participant chooses a home health agency that has provided nursing services to the participant in the past, and the agency is already familiar with the participant's health status, a Nursing Evaluation Visit is not required.
- This service must be provided by an RN employed by, or a self-employed RN contracted by, the Attendant Care Level II provider.
- A Nursing Evaluation Visit is not conducted when a participant chooses to self-direct Attendant Care Services.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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 | Self-Employed Registered Nurse licensed in Kansas |
| Agency | County Health Department; Medicare certified or KDHE licensed Home Health Agency; KDADS licensed Assisted Living Facility, Residential Health Care Facility, and Home Plus |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Nursing Evaluation Visit**

**Provider Category:**

Individual

**Provider Type:**

Self-Employed Registered Nurse licensed in Kansas

**Provider Qualifications**

**License** *(specify):*

K.S.A. 65-1113 et seq.
K.A.R. 60-3-101 et seq.

**Certificate** *(specify):*

**Other Standard** *(specify):*

K.A.R. 30-5-59

All standards, certifications and licenses that are required for the specific field through which service is provided including but not limited to: professional license / certification if required; adherence to KDADS's training and professional development requirements; maintenance of clear background as evidenced through background checks of; KBI, APS,CPS, Nurse Aid Registry, and Motor Vehicle screen.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.

**Frequency of Verification:**

This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Nursing Evaluation Visit**

**Provider Category:**

Agency

**Provider Type:**

County Health Department; Medicare certified or KDHE licensed Home Health Agency; KDADS licensed Assisted Living Facility, Residential Health Care Facility, and Home Plus

**Provider Qualifications**

**License** *(specify):*

K.S.A. 39-923 et seq.
K.S.A. 65-5101 et seq.
K.A.R. 26-39-101
K.A.R. 28-51-100 et seq.

**Certificate** *(specify):*

**Other Standard** *(specify):*

K.S.A. 65-201 et seq.describes local health departments.
K.A.R. 30-5-59,is the provider participation requirements for Medicaid which requires but not limited to: application to be submitted; specified credentials be maintained; notification of change of ownership; recordkeeping; accept payment in full, not charge customers for services covered by the program.

All standards, certifications and licenses that are required for the specific field through which service is provided including but not limited to: professional license / certification if required; adherence to KDADS's training and professional development requirements; maintenance of

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.

**Frequency of Verification:**

This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.

## 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:**

Oral Health Services

**HCBS Taxonomy:**

**Category 1:**

11 Other Health and Therapeutic Services
12 Services Supporting Self-Direction

**Sub-Category 1:**

11070 dental services
11080 occupational therapy

**Category 2:**

17 Other Services

**Sub-Category 2:**

**Category 3:**

17 Other Services

**Sub-Category 3:**

**Category 4:**

17 Other Services

**Sub-Category 4:**

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

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

**Service Definition** *(Scope):*

Oral Health Services shall mean accepted dental procedures, to include diagnostic, prophylactic, and restorative care, and allow for the purchase, adjustment, and repair of dentures, which are provided to adults (age 65 and older) who are enrolled in the HCBS Frail Elderly waiver. Anesthesia services provided in the dentist's office and billed by the dentist shall be included within the definition of oral health services.

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

LIMITATIONS:
- Oral Health Services are limited to the participant's assessed level of service need, as specified in the participant's Plan of Care, subject to an exception process established by the state. All participants are held to the same criteria when qualifying for an exception in accordance with the established KDADS policies and guidelines.

Crisis exception criteria:

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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 | Dentist or Dental Hygienist |
| Agency | Clinic with individuals licensed as a dentist or dental hygienist |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Oral Health Services**

**Provider Category:**

Individual

**Provider Type:**

Dentist or Dental Hygienist

**Provider Qualifications**

**License** *(specify):*

K.S.A. 65-1421 et seq.

**Certificate** *(specify):*

**Other Standard** *(specify):*

K.A.R. 30-5-59,is the provider participation requirements for Medicaid which requires but not limited to: application to be submitted; specified credentials be maintained; notification of change of ownership; recordkeeping; accept payment in full, not charge customers for services covered by the program.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.

**Frequency of Verification:**

This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Oral Health Services**

**Provider Category:**

Agency

**Provider Type:**

Clinic with individuals licensed as a dentist or dental hygienist

**Provider Qualifications**

**License** *(specify):*

K.S.A. 65-1421 et seq.

**Certificate** *(specify):*

**Other Standard** *(specify):*

K.A.R. 30-5-59,is the provider participation requirements for Medicaid which requires but not limited to: application to be submitted; specified credentials be maintained; notification of change of ownership; recordkeeping; accept payment in full, not charge customers for services covered by the program.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.

**Frequency of Verification:**

This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.

## 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:**

Personal Care Services - Provider Directed

**HCBS Taxonomy:**

**Category 1:**

08 Home-Based Services
09 Caregiver Support

**Sub-Category 1:**

08010 home-based habilitation
08020 home health aide

**Category 2:**

08 Home-Based Services
09 Caregiver Support

**Sub-Category 2:**

08030 personal care
08040 companion

**Category 3:**

17 Other Services

**Sub-Category 3:**

**Category 4:**

17 Other Services

**Sub-Category 4:**

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

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

**Service Definition** *(Scope):*

Personal Care Service (PCS) is not available as a State plan service. The functions of a PCS includes but is not limited to assisting with activities of daily living ADLs (bathing, grooming, toileting, transferring), health maintenance activities (including but not limited to extension of therapies), feeding, mobility and exercises, socialization and recreation activities. The PCS supports the participant in accessing medical services and normal daily activities by accompanying the participant to accomplish tasks as listed within the scope of service in accordance with K.S.A 65-5115 and K.A.R. 28-51-113.

PCS can be provided and reimbursed based on the assessed needs of the participant as identified on the participant's Plan of Care (POC).

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

LIMITATIONS:

- Attendant must be 18 years or older
- Covered ADL and IADL services are limited as defined within the MCO's needs assessment and approved Plan of Care (POC)
- PCS is limited to a maximum of 48 units (12 hours) per day of any combination of Provider-directed Level I, Provider-directed Level II, and Self-directed.
- Transportation is not covered with this service, but if medically necessary, it may be covered through regular 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 | Level I Service A: Non-medical resident care facility licensed by Department of Children and Families |
| Agency | Level I Service A: Entities not licensed by DCF, KDADS or KDHE |
| Agency | Level III KDADS licensed Assisted Living Facility, Residential Health Care Facility, Home Plus |
| Agency | Levels I & II, Services A - D: Local Health Department |
| Agency | Level I Service A or B: Medicare certified or KDHE licensed Home Health Agency; KDADS licensed Boarding Care Home |
| Agency | Level II Service C or D: Medicare certified or KDHE licensed Home Health Agency; |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Personal Care Services - Provider Directed**

**Provider Category:**

Agency

**Provider Type:**

Level I Service A: Non-medical resident care facility licensed by Department of Children and Families

**Provider Qualifications**

**License** *(specify):*

K.S.A. 75-3307(b)

K.A.R. 30-42-6 et seq.

**Certificate** *(specify):*

**Other Standard** *(specify):*

K.A.R. 30-5-59,is the provider participation requirements for Medicaid which requires but not limited to: application to be submitted; specified credentials be maintained; notification of change of ownership; recordkeeping; accept payment in full, not charge customers for services covered by the program.

All standards, certifications and licenses that are required for the specific field through which service is provided including but not limited to: professional license / certification if required; adherence to KDADS's training and professional development requirements; maintenance of clear background as evidenced through background checks of: KBI, APS CPS, Nurse Aid Registry, and Motor Vehicle screen.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.

**Frequency of Verification:**

This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Personal Care Services - Provider Directed**

**Provider Category:**

Agency

**Provider Type:**

Level I Service A: Entities not licensed by DCF, KDADS or KDHE

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*

K.A.R. 30-5-59,is the provider participation requirements for Medicaid which requires but not limited to: application to be submitted; specified credentials be maintained; notification of change of ownership; recordkeeping; accept payment in full, not charge customers for services covered by the program.
Entities not licensed by DCF, KDADS, or KDHE must provide the following:
1) A certified copy of its Articles of Incorporation or Articles of Organization. If a corporation or limited liability company is organized in a jurisdiction outside the state of Kansas, the entity shall provide written proof that it is authorized to do business in the state of Kansas.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.

**Frequency of Verification:**

This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Personal Care Services - Provider Directed**

**Provider Category:**

Agency

**Provider Type:**

Level III KDADS licensed Assisted Living Facility, Residential Health Care Facility, Home Plus

**Provider Qualifications**

**License** *(specify):*

K.S.A. 39-923 et.seq.
K.A.R. 26-39-101 et.seq.

**Certificate** *(specify):*

**Other Standard** *(specify):*

K.A.R. 30-5-59,is the provider participation requirements for Medicaid which requires but not limited to: application to be submitted; specified credentials be maintained; notification of change of ownership; recordkeeping; accept payment in full, not charge customers for services covered by the program.

All standards, certifications and licenses that are required for the specific field through which service is provided including but not limited to: professional license / certification if required; adherence to KDADS's training and professional development requirements; maintenance of clear background as evidenced through background checks of: KBI, APS CPS, Nurse Aid Registry, and Motor Vehicle screen.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.

**Frequency of Verification:**

This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Personal Care Services - Provider Directed**

**Provider Category:**

Agency

**Provider Type:**

Levels I & II, Services A - D: Local Health Department

**Provider Qualifications**

**License** *(specify):*

K.S.A. 65-5101
K.S.A. 65-5102
K.S.A. 65-5115
K.A.R. 28-51-100 et seq.

**Certificate** *(specify):*

**Other Standard** *(specify):*

K.S.A. 65-201 et seq.describes local health departments.
K.A.R. 30-5-59,is the provider participation requirements for Medicaid which requires but not limited to: application to be submitted; specified credentials be maintained; notification of change of ownership; recordkeeping; accept payment in full, not charge customers for services covered by the program.

All standards, certifications and licenses that are required for the specific field through which service is provided including but not limited to: professional license / certification if required; adherence to KDADS's training and professional development requirements; maintenance of

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.

**Frequency of Verification:**

This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Personal Care Services - Provider Directed**

**Provider Category:**

Agency

**Provider Type:**

Level I Service A or B: Medicare certified or KDHE licensed Home Health Agency; KDADS licensed Boarding Care Home

**Provider Qualifications**

**License** *(specify):*

K.S.A. 65-5101 et seq.
K.S.A. 75-3307 (b)
K.A.R. 28-51-100 et seq.
K.S.A. 39-923 et.seq.
K.A.R. 26-39-101 et.seq.

**Certificate** *(specify):*

**Other Standard** *(specify):*

K.A.R. 30-5-59,is the provider participation requirements for Medicaid which requires but not limited to: application to be submitted; specified credentials be maintained; notification of change of ownership; recordkeeping; accept payment in full, not charge customers for services covered by the program.

All standards, certifications and licenses that are required for the specific field through which service is provided including but not limited to: professional license / certification if required; adherence to KDADS's training and professional development requirements; maintenance of clear background as evidenced through background checks of: KBI, APS CPS, Nurse Aid Registry, and Motor Vehicle screen.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.

**Frequency of Verification:**

This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Personal Care Services - Provider Directed**

**Provider Category:**

Agency

**Provider Type:**

Level II Service C or D: Medicare certified or KDHE licensed Home Health Agency;

**Provider Qualifications**

**License** *(specify):*

K.S.A. 65-5101 et seq.
K.S.A. 75-3307(b)
K.A.R. 28-51-100 et seq.

**Certificate** *(specify):*

**Other Standard** *(specify):*

K.A.R. 30-5-59,is the provider participation requirements for Medicaid which requires but not limited to: application to be submitted; specified credentials be maintained; notification of change of ownership; recordkeeping; accept payment in full, not charge customers for services covered by the program.

All standards, certifications and licenses that are required for the specific field through which service is provided including but not limited to: professional license / certification if required; adherence to KDADS's training and professional development requirements; maintenance of clear background as evidenced through background checks of: KBI, APS CPS, Nurse Aid Registry, and Motor Vehicle screen.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.

**Frequency of Verification:**

This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.

## 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:**

Personal Care Services - Self-Directed

**HCBS Taxonomy:**

**Category 1:**

08 Home-Based Services
09 Caregiver Support

**Sub-Category 1:**

08010 home-based habilitation
08020 home health aide

**Category 2:**

08 Home-Based Services
09 Caregiver Support

**Sub-Category 2:**

08030 personal care
08040 companion

**Category 3:**

17 Other Services

**Sub-Category 3:**

**Category 4:**

17 Other Services

**Sub-Category 4:**

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

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

**Service Definition** *(Scope):*

Personal Care Service (PCS) is not available as a State plan service. The functions of a PCS includes but is not limited to assisting with activities of daily living ADLs (bathing, grooming, toileting, transferring), health maintenance activities (including but not limited to extension of therapies), feeding, mobility and exercises, socialization and recreation activities. The PCS supports the participant in accessing medical services and normal daily activities by accompanying the participant to accomplish tasks as listed within the scope of service in accordance with K.S.A 65-5115 and K.A.R. 28-51-113.

PCS can be provided and reimbursed based on the assessed needs of the participant as identified on the participant's Plan of Care (POC).

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

LIMITATIONS:
- Direct support workers must be 18 years of age or older.
- A participant who has a guardian and/or conservator cannot choose to self-direct his or her PCS; however, a guardian and/or conservator can make that choice on the ward's behalf.
- It is the expectation that program participants who need assistance with instrumental activities of daily living (IADL) tasks receive those supports from informal supports, if available. These informal supports may include relatives or friends that live with the person receiving HCBS services. These informal

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

- [x] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Enrolled FMS Providers |
| Individual | Individual Personal Care Worker |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Personal Care Services - Self-Directed**

**Provider Category:**

Agency

**Provider Type:**

Enrolled FMS Providers

**Provider Qualifications**

**License** *(specify)*:

**Certificate** *(specify)*:

**Other Standard** *(specify)*:

Must be an enrolled Medicaid provider of Attendant Care Services - Self-Direct

1. Each potential Agency With Choice Financial Management Services (FMS) entity must complete and maintain in good standing:
a. KDADS Provider Agreement between KDADS and the FMS agency
i. Applications are available on the following website:

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Kansas Department of Health and Environment (SSMA), KDADS-Quality Management Specialists will review and collect data to support whether the MCOs are assuring the FMS providers are complying with the qualifications as specified in the waiver.and KanCare MCOs are responsible for ensuring the FMS provider met the approved standards

**Frequency of Verification:**

This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Personal Care Services - Self-Directed**

**Provider Category:**

Individual

**Provider Type:**

Individual Personal Care Worker

**Provider Qualifications**

**License** *(specify):*

N/A

**Certificate** *(specify):*

N/A

**Other Standard** *(specify):*

- Must sign an agreement with a Medicaid-enrolled Financial Management Services (FMS) provider;
- Must be at least eighteen years of age or older;

All standards, certifications and licenses that are required for the specific field through which service is provided including but not limited to: professional license / certification if required; adherence to KDADS's training and professional development requirements; maintenance of clear background as evidenced through background checks of: KBI, APS CPS, Nurse Aid Registry, and Motor Vehicle screen". Any provider found identified to have been substantiated for prohibited offenses as listed in KSA 39-970 & 65-5117 is not eligible for reimbursement of

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.

**Frequency of Verification:**

This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.

## 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:**

Personal Emergency Response

**HCBS Taxonomy:**

**Category 1:**

14 Equipment, Technology, and Modifications
15 Non-Medical Transportation

**Sub-Category 1:**

14010 personal emergency response system (PERS)
14020 home and/or vehicle accessibility adaptations

**Category 2:**

14 Equipment, Technology, and Modifications
15 Non-Medical Transportation

**Sub-Category 2:**

14031 equipment and technology
14032 supplies

**Category 3:**

17 Other Services

**Sub-Category 3:**

**Category 4:**

17 Other Services

**Sub-Category 4:**

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

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

**Service Definition** *(Scope):*

Diagnosis alone does not determine need for this service. The MCO Care Coordinator authorizes the need for this service based on an underlying medical or functional impairment.

This service does not duplicate other waiver services.

Personal Emergency Response units are electronic devices and have portable buttons worn by the participant. These units provide 24 hour a day on-call support to a participant having a medical or emergency need that could become critical at anytime.

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

LIMITATIONS:

- Maintenance of rental equipment is the responsibility of the provider
- Repair/replacement of rental equipment is not covered
- Rental, but not purchase, of this service is covered
- Call lights do not meet this definition

**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** | **Personal Emergency Response Co; Medicare certified or KDHE licensed Home Health Agency; KDHE licensed Hospital; KDADS licensed NF, ALF, RHCF, Home Plus; and Emergency Medical Services** |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Personal Emergency Response**

**Provider Category:**

Agency

**Provider Type:**

Personal Emergency Response Co; Medicare certified or KDHE licensed Home Health Agency; KDHE licensed Hospital; KDADS licensed NF, ALF, RHCF, Home Plus; and Emergency Medical Services

**Provider Qualifications**

**License** *(specify):*

K.S.A. 39-923 et seq.
K.S.A. 65-425 et seq.
K.S.A. 65-5101 et seq.
K.A.R. 26-39-101
K.A.R. 28-34-2

**Certificate** *(specify):*

**Other Standard** *(specify):*

K.S.A. 65-6112 et seq.describes emergency medical services.
K.A.R. 30-5-59,is the provider participation requirements for Medicaid which requires but not limited to: application to be submitted; specified credentials be maintained; notification of change of ownership; recordkeeping; accept payment in full, not charge customers for services covered by the program.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.

**Frequency of Verification:**

This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.

## 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:**

Sleep Cycle Support - Self-Directed

**HCBS Taxonomy:**

**Category 1:**

08 Home-Based Services
09 Caregiver Support

**Sub-Category 1:**

08040 companion
08050 homemaker

**Category 2:**

17 Other Services

**Sub-Category 2:**

**Category 3:**

17 Other Services

**Sub-Category 3:**

**Category 4:**

17 Other Services

**Sub-Category 4:**

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

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

**Service Definition** *(Scope):*

This service provides non-nursing physical assistance and/or supervision during the participant's normal sleeping hours in the participant's place of residence, excluding adult care homes. This service includes physical assistance or supervision with toileting, transferring and mobility, and prompt and reminding of medication. This service shall not duplicate other waiver services.

Direct support worker may sleep but must awaken as needed to provide assistance as identified in the participant's service plan. Direct support worker must provide the participant a mechanism to gain their attention or awaken them at any time. Direct support worker must be ready to call a physician, hospital or other medical personnel should an emergency arise. Direct support worker must submit a report to the managed care organization of involvement within the first business day following any emergency response provided the participant.

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

LIMITATIONS:

- Sleep Cycle Support is limited to the participant's assessed level of service need, as specified in the participant's Plan of Care, not to exceed twelve (12) hours per 24-hour time period, subject to an exception process established by the state. All participants are held to the same criteria when qualifying for an exception, in accordance with the established KDADS policies and guidelines.

Crisis exception criteria:

**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 | Enrolled FMS Provider |
| Individual | Individual Sleep Cycle Support Worker |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Sleep Cycle Support - Self-Directed**

**Provider Category:**

Agency

**Provider Type:**

Enrolled FMS Provider

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*

Must be an enrolled Medicaid provider of Sleep Cycle Support

1. Each potential Agency With Choice Financial Management Services (FMS) entity must complete and maintain in good standing:
a. KDADS Provider Agreement
i. Applications are available on the following website:

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.

**Frequency of Verification:**

Kansas Department of Health and Environment (SSMA), KDADS-Quality Management Specialists will review and collect data to support whether the MCOs are assuring the FMS providers are complying with the qualifications as specified in the waiver and KanCare MCOs are responsible for ensuring the FMS provider met the approved standards. This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Sleep Cycle Support - Self-Directed**

**Provider Category:**

Individual

**Provider Type:**

Individual Sleep Cycle Support Worker

**Provider Qualifications**

**License** *(specify):*

N/A

**Certificate** *(specify):*

N/A

**Other Standard** *(specify):*

- Must sign an agreement with a Medicaid-enrolled Financial Management Services (FMS) provider;
- Must be at least eighteen years of age or older;
- Sleep Cycle Support worker must have a permanent residence separate and apart from the participant.

All standards, certifications and licenses that are required for the specific field through which service is provided including but not limited to: professional license / certification if required; adherence to KDADS's training and professional development requirements; maintenance of

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.

**Frequency of Verification:**

This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.

## 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
12 Services Supporting Self-Direction

**Sub-Category 1:**

11010 health monitoring
11020 health assessment

**Category 2:**

17 Other Services

**Sub-Category 2:**

**Category 3:**

17 Other Services

**Sub-Category 3:**

**Category 4:**

17 Other Services

**Sub-Category 4:**

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

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

**Service Definition** *(Scope):*

This service provides a Wellness Monitoring visit through nursing assessment by a licensed nurse. This service provides an opportunity for the nurse to check a participant's health concerns that have been identified by the manage care involvement. This service reduces the need for routine physician/health professional visits and care in more costly settings. Any changes in the health status of the participant during the visits are then brought to the attention of the managed care entity and the physician as needed. A written report must be sent to the Managed care organization involved documenting the participant's status within two (2) weeks of the nurse visit.

This service includes nursing diagnosis, nursing treatment, counseling and health teaching, administration/supervision of nursing process, teaching of the nursing process, and execution of the medical regimen.

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

LIMITATIONS:

•Wellness monitoring is limited to one face-to-face visit every 55 days, or less frequently, as determined by the MCO Care Coordinator.
•Wellness Monitoring requires a written follow-up report within two weeks of the face-to-face visit by the licensed nurse. This report will be sent to the manage care involvement regarding the findings and recommendation of the licensed nurse.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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** | **Self-employed Registered Nurse licensed in Kansas** |
| **Agency** | **County Health Department; Medicare certified or KDHE licensed Home Health Agency; KDADS licensed Assisted Living Facility, Residential Health Care Facility, and Home Plus** |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Wellness Monitoring**

**Provider Category:**

Individual

**Provider Type:**

Self-employed Registered Nurse licensed in Kansas

**Provider Qualifications**

**License** *(specify):*

K.S.A. 65-1113 et seq.
K.A.R. 60-3-101 et seq.

**Certificate** *(specify):*

**Other Standard** *(specify):*

K.A.R. 30-5-59,is the provider participation requirements for Medicaid which requires but not limited to: application to be submitted; specified credentials be maintained; notification of change of ownership; recordkeeping; accept payment in full, not charge customers for services covered by the program.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs

**Frequency of Verification:**

This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.

## 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:**

County Health Department; Medicare certified or KDHE licensed Home Health Agency; KDADS licensed Assisted Living Facility, Residential Health Care Facility, and Home Plus

**Provider Qualifications**

**License** *(specify):*

K.S.A. 39-923 et seq.
K.S.A. 65-5101 et seq.
K.A.R. 26-39-101
K.A.R. 28-51-100 et seq.

**Certificate** *(specify):*

**Other Standard** *(specify):*

K.S.A. 65-201 et seq.describes local health departments.
K.A.R. 30-5-59,is the provider participation requirements for Medicaid which requires but not limited to: application to be submitted; specified credentials be maintained; notification of change of ownership; recordkeeping; accept payment in full, not charge customers for services covered by the program.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs

**Frequency of Verification:**

This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.

## 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.*

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

## 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):

The contractor / sub contactor and /or provider agency must complete a background check to include the following: Kansas Bureau of Investigations (KBI), APS, CPS, KSBN, nurse aide registry, and motor vehicle screen on performing employee for the following waiver services:

- Financial Management Services
- Adult Day Care Edit Service
- Assistive Technology Edit Service
- Comprehensive Support –Provider directed

**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):

The contractor / sub contactor and /or provider agency must complete a background check to include the following: Kansas Bureau of Investigations (KBI), APS, CPS, KSBN, nurse aide registry, and motor vehicle screen on performing employee for the following waiver services:

- Financial Management Services
- Adult Day Care Edit Service
- Assistive Technology Edit Service
- Comprehensive Support --Provider directed

## Appendix C: Participant Services

### C-2: General Service Specifications (2 of 3)

**c. Services in Facilities Subject to §1616(e) of the Social Security Act.** *Select one:*

○ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**

⊙ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

**i. Types of Facilities Subject to §1616(e).** Complete the following table for each type of facility subject to §1616(e) of the Act:

| Facility Type | |
|---|---|
| Non-medical Resident Care Facility | |

**ii. Larger Facilities:** In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Required information is contained in Attachment #2 HCB Settings of the Main Module.

## Appendix C: Participant Services

### C-2: Facility Specifications

**Facility Type:**

Non-medical Resident Care Facility

**Waiver Service(s) Provided in Facility:**

| Waiver Service | Provided in Facility |
|---|---|
| Comprehensive Support - Self-Directed | ☐ |
| Personal Care Services - Provider Directed | ☑ |
| Home Telehealth | ☐ |
| Sleep Cycle Support - Self-Directed | ☐ |
| Assistive Technology | ☑ |
| Personal Emergency Response | ☑ |
| Nursing Evaluation Visit | ☐ |
| Adult Day Care | ☐ |
| Comprehensive Support - Provider Directed | ☑ |
| Personal Care Services - Self-Directed | ☐ |
| Oral Health Services | ☐ |
| Wellness Monitoring | ☑ |
| Financial Management Services | ☐ |

| | |
|---|---|
| **Medication Reminder** | ☑ |

**Facility Capacity Limit:**

40

**Scope of Facility Sandards.** For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

**Scope of State Facility Standards**

| Standard | Topic Addressed |
|---|---|
| Admission policies | ☑ |
| Physical environment | ☑ |
| Sanitation | ☑ |
| Safety | ☑ |
| Staff : resident ratios | ☑ |
| Staff training and qualifications | ☑ |
| Staff supervision | ☑ |
| Resident rights | ☑ |
| Medication administration | ☑ |
| Use of restrictive interventions | ☑ |
| Incident reporting | ☑ |
| Provision of or arrangement for necessary health services | ☑ |

**When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:**

Required information is contained Attachment #2 HCB Settings of the Main Module.

## 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.*

According to KAR 30-5-307, Family reimbursement restriction: (a) neither an adult participant's spouse nor a minor participant's parent shall be paid to provide HCBS services to that participant, unless all other possible options are exhausted and one of the following extraordinary criteria is met.
(1) Three HCBS provider agencies furnish written documentation that the participant's residence is so remote or rural that HCBS services are otherwise completely unavailable.
(2) Two health care professionals, including the attending physician, furnish written documentation that the participant's health, safety, or social well-being, would be jeopardized.
(3) The attending physician furnishes written documentation that, due to the advancement of chronic disease, the participant's means of communication can be understood only by the spouse or by the parent of a minor child.
(4) Three HCBS providers furnish written documentation that delivery of HCBS services to the participant poses serious health or safety issues for the provider, thereby rendering HCBS services otherwise unavailable.

**e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

○ **The State does not make payment to relatives/legal guardians for furnishing waiver services.**

◉ **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

Relatives (provided they are not the participant's spouse, Durable Power of Attorney (DPOA), or legal guardian) may provide the following services to the participant:
- Attendant Care - Self-Direct
- Comprehensive Support - Self-Direct
- Sleep Cycle Support - Self-Direct

NOTE: Under limited circumstances, a spouse may be approved to provide Attendant Care-Self Direct. (See KAR 30-5-307).

○ **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:

Consumers of the HCBS-FE waiver services have the right to choose who provides their services, within established guidelines regarding provider qualifications. Any qualified provider of those services may enroll through the Medicaid agency, Kansas Department of Health and Environment, (KDHE), for the Kansas Medical Assistance Program; and also must contract with, and meet the contracting terms of, the KanCare MCOs.

In addition to broad scale information and outreach by the state and the KanCare MCOs for all Medicaid providers, the providers that support HCBS waiver members have received additional outreach, information, transition planning and education regarding the KanCare program, to ensure an effective and smooth transition. In addition to the broader KanCare provider outreach (including educational tours and weekly stakeholder update calls), the providers that support HCBS waiver members have had focused discussions with state staff and MCO staff about operationalizing the KanCare program; about transition planning (and specific flexibility to

## Appendix C: Participant Services

### Quality Improvement: Qualified Providers

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's 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/percent of new licensed/certified waiver provider applicants that initially met licensure requirements, certification requirements, and other waiver standards prior to furnishing waiver services N=Number of new licensed/certified waiver provider applicants that initially met licensure requirements, etc.prior to furnishing waiver services D=Number of all new licensed/certified providers**

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

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval =<br>95% |
| ☑ **Other**<br>Specify:<br>KanCare Managed Care Organizations (MCOs) | ☐ **Annually** | ☑ **Stratified**<br>Describe Group:<br>Proportionate by MCO |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify:<br>KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards N=Number of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards D=Number of enrolled licensed/certified waiver providers**

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

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval =<br>95% |
| ☑ **Other**<br>Specify:<br>KanCare Managed Care Organizations (MCOs) | ☐ **Annually** | ☑ **Stratified**<br>Describe Group:<br>Proportionate by MCO |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and** | **Frequency of data aggregation and** |
|---|---|

| **analysis** *(check each that applies):* | **analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**b.** ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

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

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

**Performance Measure:**
**Number and percent of enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements N=Number enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements D=Number of enrolled non-licensed/noncertified providers**

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

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval =<br>95% |
| ☑ **Other**<br>Specify:<br>KanCare Managed Care Organizations (MCOs) | ☐ **Annually** | ☑ **Stratified**<br>Describe Group:<br>Proportionate by MCO |
| | | |

| | | |
|---|---|---|
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other** Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**Number and percent of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing waiver services N=Number of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing wavier services D=Number of all new non-licensed/non-certified providers**

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

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample** Confidence Interval = 95% |

| | | |
|---|---|---|
| ☑ **Other**<br>Specify:<br>KanCare Managed Care Organizations (MCOs) | ☐ **Annually** | ☑ **Stratified**<br>Describe Group:<br>Proportionate by MCO |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify:<br>KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

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

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

**Performance Measure:**
**Number and percent of active providers that meet training requirements N=Number of providers that meet training requirements D=Number of active providers**

**Data Source** (Select one):

**Other**
If 'Other' is selected, specify:
**Managed Care Organization (MCO) reports and record reviews**

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval =<br>95% |
| ☑ **Other**<br>Specify:<br>KanCare Managed Care Organizations (MCOs) | ☐ **Annually** | ☑ **Stratified**<br>Describe Group:<br>Proportionate by MCO |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify:<br>KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

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

Kansas uses an ongoing survey and evaluation process to verify that providers continue to meet licensing and /or certification standards and adhere to other state standards. Adult care home are licensed by the Kansas Department for Aging and Disability (KDADS) or the Kansas Department of Health and Environment (KDHE), depending on the type of facility. In-home care providers are licensed by KDHE. Both agencies utilize a similar process to evaluate providers. By statute, the average time between surveys statewide must not exceed 12 months. The surveying agency maintains a database of licensed providers and the month in which their annual surveys are due. The agencies use this database to assign surveyors each month to evaluate the providers identified.

These measures and collection/reporting protocols, together with others that are part of the KanCare Managed Care Organization (MCO) contract, are included in a statewide comprehensive KanCare QIS which is regularly reviewed and adjusted. That plan is contributed to and monitored through a state

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the State's 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 QIS and the operating protocols of the interagency monitoring team.

**ii. Remediation Data Aggregation**

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

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☑ **Other**<br>Specify:<br>KanCare Managed Care Organizations (MCOs) | ☐ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**

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

◉ **No**

○ **Yes**

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

## Appendix C: Participant Services

### C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

## Appendix C: Participant Services

### C-4: Additional Limits on Amount of Waiver Services

**a. Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- (●) **Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ( ) **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
*Furnish the information specified above.*

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
*Furnish the information specified above.*

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
*Furnish the information specified above.*

☐ **Other Type of Limit.** The State employs another type of limit.
*Describe the limit and furnish the information specified above.*

## Appendix C: Participant Services

### C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

*Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.*

The State submitted a proposed Statewide Transition Plan pending CMS approval. see Main section, attachment #2

## Appendix D: Participant-Centered Planning and Service Delivery

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

**State Participant-Centered Service Plan Title:**

Integrated Service Plan

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

- [ ] **Registered nurse, licensed to practice in the State**
- [ ] **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- [ ] **Licensed physician (M.D. or D.O)**
- [ ] **Case Manager** (qualifications specified in Appendix C-1/C-3)
- [ ] **Case Manager** (qualifications not specified in Appendix C-1/C-3).

*Specify qualifications:*

- [ ] **Social Worker**

*Specify qualifications:*

- [x] **Other**

*Specify the individuals and their qualifications:*

Kansas has contracted with three 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 Plan of Care (POC) development using their internal staff to provide that service. In addition, conflict has been mitigated by Kansas separating the level of care (LOC) determination from any HCBS delivery or POC development. Additional safeguards have been put in place to ensure that there is no conflict of interest in this function, including the operational strategies for each MCO that are described in detail at Section D1(d) of this appendix.

Regarding Amerigroup: Service plans for Amerigroup members in waivers are developed by Service Coordinators who must have at least two years of experience working with individuals with chronic illness, comorbidities, and/or disabilities in a Service Coordinator, Case Management, Advocate or similar role.

## 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.

Each participant found eligible for HCBS/FE waiver services can choose to receive services through the waiver program. The MCO is responsible for for providing service options through the HCBS/FE waiver. The participant's choice of service options is indicated on the Consumer Choice form or on the plan of care (POC).

For development of the POC, the MCO provides information on the waiver services available to the participant. The participant, MCO, and participant-authorized representatives will determine the appropriate services for the POC. Participants will be given free choice of all qualified providers of each service included in his/her written POC. The MCO presents each eligible participant a list of providers from which the participant can choose for self-directed services, if self-direction is available, and a list of service providers for agency-directed services. The MCO assists the participant with accessing information and supports from the participant's chosen provider.

## 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):

Each participant found eligible for FE waiver services can choose to receive services through the waiver program. The MCO is responsible for providing service options through the FEwaiver and the participant's choice of service options must be indicated on the Participant Choice form or on the Plan of Care (POC). This information is revisited by the MCO during the plan development process and specific services are identified that will best meet the participant's needs. During the plan of care development, the MCO will complete a needs assessment for the participant that will identify the necessary services to meet the needs of the participant.

All applicants for program services must undergo an assessment to determine functional eligibility for the program. The Functionally Eligibility Instrument (FEI) is utilized to determine the Level of Care eligibility for the HCBS program. The state's eligibility contractor conducts the assessment of the applicant within five (5) working days of the referral, unless a different timeframe is requested by the applicant or his/her legal representative, if appropriate. Participants are informed of services options available through the program by the MCO during the process of plan of care development. The participant will indicate his/her choice to receive home

## 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.

Risks are captured in the FEI. These risks include falls, behaviors, support systems, cognitive status, abuse, neglect, and exploitation. These issues are addressed in both the development of the POC and needs assessment. Identified risks are discussed with the participant and/or participant's representatives. All participants are required to have a back-up plan for staffing requirements and emergency situations to mitigate the risk of loss of services as outlined in the POC.

Participants are assessed on each risk, and service options are discussed and implemented, as needed, based on risk assessment results. Resources are available to meet participant needs for assistive equipment. State licensure requires that Home Health Agencies have back-up staff available to provide services and state regulations require that assisted living facilities, residential health care facilities, and homes plus have a written emergency management plan. If the participant chooses to self-direct, the participant is accountable for having staff available to meet their care needs.

## 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.

If the participant chooses to receive waiver services, the MCO provides a list of all service access agencies, including Financial Management Services (FMS), to the participant and assists with accessing information and supports from the participant's preferred qualified provider. These service access agencies have and make available to the participant the names and contact information of qualified providers of the waiver services identified in the POC.

The State assures that each participant found eligible for the waiver will be given free choice of all qualified providers of each service included in his/her written POC. The MCO presents each eligible participant a complete list of providers from which the participant can choose for self-directed services and a list of service providers for agency-directed services. The MCO assists the participant with assessing information and supports from the participant's preferred provider. These service access agencies have, and make available to the participant, the names and contact information of qualified providers of the waiver services identified in the

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (7 of 8)

**g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The consumer's chosen MCO and the consumer develop the consumer's Plan of Care from information gathered in the assessment. Further monitoring of services is conducted by the state consistent with the comprehensive KanCare quality improvement strategy. Included in that strategy is review of data that addresses:

- Access to services
- Freedom of choice
- Consumers needs met

## Appendix D: Participant-Centered Planning and Service Delivery

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

**h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

*Specify the other schedule:*

i. **Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- [ ] **Medicaid agency**
- [ ] **Operating agency**
- [ ] **Case manager**
- [x] **Other**

*Specify:*

Service plans and related documentation will be maintained by the participant's chosen KanCare MCO, and will be retained at least as long as this requirement specifies.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-2: Service Plan Implementation and Monitoring

a. **Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The three KanCare contracting MCOs are responsible for monitoring the implementation of the POC developed by the participant and their MCO. To ensure the health and welfare of the participant, input from the HCBS/FE Program Manager, and involvement of the Quality Management Service (QMS) staff may be required (which includes all of the HCBS waiver performance measures).
MCOs will continually monitor the POC and participant needs to ensure:

- Services are delivered according to the POC;
- Participants are made aware of all services available through the HCBS/FE waiver

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:*

A participant who has a guardian and/or conservator cannot choose to self-direct his or her PCS; however, a guardian and/or conservator can make that choice on the ward's behalf. Family members, legal guardians, etc. cannot be responsible for the development of PC Service plan but they can participate in the process.

CMS has requested Kansas to provide specific information on how it mitigates potential conflict of interest and ensures that the guardian being paid as the provider and developing the plan of care with MCOs is in the best interest of the consumer in compliance with 42 CFR §441.301(b)(1)). Kansas is committed to supporting families and individuals who are aging and disabled, so that they can be independent and included in their home and community. To comply with the HCBS Final Rule, the following assurances are proposed to mitigate potential conflicts between the role of guardian, legal guardian, durable power of

## Appendix D: Participant-Centered Planning and Service Delivery

### Quality Improvement: Service Plan

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

a. **Methods for Discovery: Service Plan Assurance/Sub-assurances**

***The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.***

i. **Sub-Assurances:**

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

**Performance Measures**

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

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is*

*analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Number and percent of waiver participants whose service plans address participants' goals N=Number of waiver participants whose service plans address participants'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 = 95% |
| ☑ **Other** Specify: KanCare Managed Care Organizations (MCOs) | ☐ **Annually** | ☑ **Stratified** Describe Group: Proportionate by MCO |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

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

| | |
|---|---|
| KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency | |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment N=Number of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment D= Number of waiver participants whose service plans were reviewed**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Record reviews**

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval =<br>95% |
| ☑ **Other**<br>Specify:<br>KanCare Managed Care Organizations (MCOs) | ☐ **Annually** | ☑ **Stratified**<br>Describe Group:<br>Proportionate by MCO |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify:<br>KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of waiver participants whose service plans address health and safety risk factors N=Number of waiver participants whose service plans 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 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**<br>Confidence Interval =<br>95% |
| ☑ **Other**<br>Specify:<br>KanCare Managed Care Organizations (MCOs) | ☐ **Annually** | ☑ **Stratified**<br>Describe Group:<br>Proportionate by MCO |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify:<br>KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**b.** ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

**Performance Measures**

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

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

**Performance Measure:**
**Number and percent of waiver participants (or their representatives) who were present and involved in the development of their service plan N=Number of waiver participants (or their representatives) who were present and involved in the development of their service plan 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**<br>Confidence Interval =<br>95% |
| ☑ **Other** | ☐ **Annually** | ☑ **Stratified** |

| | | |
|---|---|---|
| Specify: KanCare Managed Care Organizations (MCOs) | | Describe Group: Proportionate by MCO |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☑ **Other** Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**Number and percent of waiver participants whose service plans were developed according to the processes in the approved waiver N=Number of waiver participants whose service plans were developed according to the processes in the approved waiver D=Number of waiver participants whose service plans were reviewed**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Record reviews**

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☑ **Representative Sample** |

| | | |
|---|---|---|
| | | Confidence Interval = 95% |
| ☑ **Other** Specify: KanCare Managed Care Organizations (MCOs) | ☐ **Annually** | ☑ **Stratified** Describe Group: Proportionate by MCO |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☑ **Other** Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**c.** ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's 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 waiver participants with documented change in needs whose service plan was revised, as needed to address the change N=Number of waiver participants with documented change in needs whose service plan was revised, as needed to address the change 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**<br>Confidence Interval =<br>95% |
| ☑ **Other**<br>Specify:<br>KanCare Managed Care Organizations (MCOs) | ☐ **Annually** | ☑ **Stratified**<br>Describe Group:<br>Proportionate by MCO |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☑ **Annually** |

| | |
|---|---|
| KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency | |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of service plans reviewed before the waiver participant's annual redetermination date N=Number of service plans reviewed before the waiver participant's annual redetermination date 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**<br>Confidence Interval =<br>95% |
| ☑ **Other**<br>Specify:<br>KanCare Managed Care Organizations (MCOs) | ☐ **Annually** | ☑ **Stratified**<br>Describe Group:<br>Proportionate by MCO |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify:<br>KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**d.** ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

**Performance Measures**

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

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

**Performance Measure:**
**Number and percent of survey respondents who reported receiving all services as specified in their service plan N=Number of survey respondents who reported receiving all services as specified in their service plan D=Number of waiver participants interviewed by QMS (Quality Management staff)**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Customer interviews, on-site**

| **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**<br>Confidence Interval =<br>95% |
| ☑ **Other**<br>Specify:<br>KanCare Managed Care Organizations (MCOs) | ☐ **Annually** | ☑ **Stratified**<br>Describe Group:<br>Proportionate by MCO |
| | ☐ **Continuously and** | ☐ **Other** |

| | | |
|---|---|---|
| | **Ongoing** | Specify: |
| | ☐ **Other**<br>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**<br>Specify:<br>KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan N=Number of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan 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**<br>Confidence Interval =<br>95% |
| ☑ **Other** | ☐ **Annually** | ☑ **Stratified** |

| | | |
|---|---|---|
| Specify: KanCare Managed Care Organizations | | Describe Group: Proportionate by MCO |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Electronic Visit Verification (EVV) reports and record reviews**

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☑ **Representative Sample** Confidence Interval = 95% |
| ☑ **Other** Specify: KanCare Managed Care Organizations (MCOs) | ☐ **Annually** | ☑ **Stratified** Describe Group: Proportionate by MCO |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and** | **Frequency of data aggregation and** |
|---|---|

| **analysis** *(check each that applies):* | **analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☑ **Other**<br>Specify:<br>KanCare MCOs participate in analysis of this measure's results as dtermined by the State operating agency | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**e.** ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and 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 community-based services v. an institutional alternative N=Number of waiver participants whose record contains documentation indicating a choice of community-based services D=Number of waiver participants whose files are reviewed for the documentation**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Record reviews**

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval =<br>95% |
| ☑ **Other**<br>Specify: | ☐ **Annually** | ☑ **Stratified**<br>Describe Group: |

| | | |
|---|---|---|
| KanCare Managed Care Organizations | | Proportionate by MCO |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify:<br>KanCare MCOs participate in the analysis of this measure's results as determined by the State operating agency | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of waiver participants whose record contains documentation indicating a choice of waiver services N=Number of waiver participants whose record contains documentation indicating a choice of waiver services D= Number of waiver participants whose files are reviewed for the documentation**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Record reviews**

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

| | | |
|---|---|---|
| | | 95% |
| ☑ **Other**<br>Specify:<br>KanCare Managed Care Organizations (MCOs) | ☐ **Annually** | ☑ **Stratified**<br>Describe Group:<br>Proportionate by MCO |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify:<br>KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**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 files are reviewed for the documentation**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Record reviews**

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

| *each that applies):* | *each that applies):* | |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval =<br>95% |
| ☑ **Other**<br>Specify:<br>KanCare Managed Care Organizations (MCOs) | ☐ **Annually** | ☑ **Stratified**<br>Describe Group:<br>Proportionate by MCO |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify:<br>KanCare MCOs participate in the analysis of this measure's results as determined by the State operating agency | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**

**Number and percent of waiver participants whose record contains documentation indicating a choice of waiver service providers N=Number of waiver participants whose record contains documentation indicating a choice of waiver service providers D= Number of waiver participants whose files are reviewed for the documentation**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Record reviews**

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval =<br>95% |
| ☑ **Other**<br>Specify:<br>KanCare Managed Care Organizations (MCOs) | ☐ **Annually** | ☑ **Stratified**<br>Describe Group:<br>Proportionate by MCO |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify:<br>KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

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

Kansas Department of Health and Environment, Division of Health Care Finance (KDHE), the single state Medicaid agency, and Kansas Department for Aging and Disability Services (KDADS) work together to develop state operating agency priority identification regarding all waiver assurances and minimum standards/basic assurances. The state agencies work in partnership with participants, advocacy organizations, provider groups and other interested stakeholders to monitor the state quality strategy and performance standards and discuss priorities for remediation and improvement. The state quality improvement strategy includes protocols to review cross-service system data to identify trends and opportunities for improvement related to all Kansas waivers, policy and procedure development and systems change initiatives.

Data gathered by KDADS Regional Staff during the Quality Survey Process, and data provided by the KanCare MCOs, is compiled quarterly for evaluation and trending to identify areas for improvement. Upon completion of identified areas of improvement this information is compiled into reports and shared

**b. Methods for Remediation/Fixing Individual Problems**

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

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

**ii. Remediation Data Aggregation**

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

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☑ **Other**<br>Specify:<br>KanCare Managed Care Organizations (MCOs) | ☑ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**

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

◉ **No**

○ **Yes**

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

## Appendix E: Participant Direction of Services

**Applicability** *(from Application Section 3, Components of the Waiver Request)*:

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

*CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence*

*Plus designation when the waiver evidences a strong commitment to participant direction.*

**Indicate whether Independence Plus designation is requested** *(select one):*

- ○ **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- ◉ **No. Independence Plus designation is not requested.**

## Appendix E: Participant Direction of Services

### E-1: Overview (1 of 13)

**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 HCBS/FE waiver services have the opportunity to choose the KanCare Managed Care Organization (MCO) that will support them in overall service access and care management. The opportunity for participant direction (self-direction) of Service Provider 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 Service Provider, back-up SERVICE PROVIDERS with Service Providers;

## 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 option is available for the following services:

- Personal Care Services
- Sleep Cycle Support
- Comprehensive Support

## 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 attendant care services, 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 limitation to Service Providers services;
- the need to select and enter into an agreement with an enrolled FMS(FMS) provider;
- related responsibilities (outlined in E-1(a));

## 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 participant 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. A DPOA for health care decisions, if activated, cannot be the participant's paid attendant for SERVICE PROVIDERS and/or Sleep Cycle Support.

Safeguards include:

## 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 |
|---|---|---|
| **Comprehensive Support - Self-Directed** | ☑ | ☐ |
| **Sleep Cycle Support - Self-Directed** | ☑ | ☐ |
| **Personal Care Services - Self-Directed** | ☑ | ☐ |
| **Financial Management Services** | ☑ | ☐ |

## 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**
- [x] **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 FMS 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 FMS are required to submit a signed Provider Agreement to the State Operating Agency, KDADS, prior to enrollment 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. In addition, organizations are required to submit the following documents with the signed agreement:
• Secretary of State Certificate of Corporate Good Standing

**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 participant through the electronic Plans of Care system (MMIS). The per member per month payment was estimated based upon a formula that included all direct and indirect costs to payroll agents and an average hourly rate for direct care workers. Information was gathered as part of a Systems Transformation Grant study conducted by Myers & Stauffer. Under the KanCare program, FMS providers will contract with MCOs for final payment rates, which cannot be less than the current FFS 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:

- [x] **Assist participant in verifying support worker citizenship status**
- [x] **Collect and process timesheets of support workers**
- [x] **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 [KDHE]). Requirements include agreements between the FMS provider and the participant, Direct Support Worker and the State Medicaid Agency and verification of processes to ensure the submission of Direct Support 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 Support Worker satisfaction; maintain a grievance process for Direct Support Workers; and offer choice of Information and Assistance services.

## 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:*

- [x] **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 |
|---|---|
| **Comprehensive Support - Self-Directed** | ☑ |
| **Personal Care Services - Provider Directed** | ☐ |
| **Home Telehealth** | ☐ |
| **Sleep Cycle Support - Self-Directed** | ☑ |
| **Assistive Technology** | ☐ |
| **Personal Emergency Response** | ☐ |

| | |
|---|---|
| **Nursing Evaluation Visit** | ☐ |
| **Adult Day Care** | ☐ |
| **Comprehensive Support - Provider Directed** | ☐ |
| **Personal Care Services - Self-Directed** | ☑ |
| **Oral Health Services** | ☐ |
| **Wellness Monitoring** | ☐ |
| **Financial Management Services** | ☑ |
| **Medication Reminder** | ☐ |

☐ **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:*

## Appendix E: Participant Direction of Services

### E-1: Overview (11 of 13)

**l. 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.
At any time, if the participant chooses to discontinue the self-direct option, he/she is to:

- Notify all providers as well as the FMS (FMS) provider.
- Maintain continuous attendant coverage for authorized Attendant Care Services and/or Sleep Cycle

## 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 MCO may, if appropriate discontinue the participants choice to direct their services when, in the MCOs professional judgment through observation and documentation, it is not in the best interest of the participant to participant-direct their services. The MCO will make the recommendation to KDADS and there must concurrence on the reason to remove participant-direction and the following conditions will be compromised if the participant-direction continues:

- 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 have been exhausted;
- The PCS is not providing the services as outlined on the PCS Skilled worksheet, and the situation cannot be remedied;

## 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** | 3547 | |
| **Year 2** | 3646 | |
| **Year 3** | 3744 | |
| **Year 4** | 3843 | |
| **Year 5** | 3942 | |

## 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 services 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.**
☑ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

- [x] **Determine staff wages and benefits subject to State limits**
- [x] **Schedule staff**
- [x] **Orient and instruct staff in duties**
- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [x] **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.

Kansas has contracted with a contractor to conduct level of care determinations. Decisions made by the contractor are subject to state fair hearing review, and notice of that right and related process will be provided by the contractor with their decision on the LOC determination/redetermination.

Kansas has contracted with three KanCare managed care organizations (MCOs) who are required to have grievance and appeal processes that meet all relevant federal and state standards, including state fair hearings and expedited appeals. Each MCO has established operational processes regarding these issues, about which they must inform every member. In addition, the State will review member grievances/appeals during the initial implementation of the KanCare program on a daily basis to see if there are issues with getting into care, ability to get prescriptions or ability to reach a live person on the phone. The State will report to CMS the number and frequency of these types of complaints/grievances during the initial transition period, and will continue to monitor this issue throughout the KanCare program.

## Appendix F: Participant-Rights

### Appendix F-2: Additional Dispute Resolution Process

**a. Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The State operates an additional dispute resolution process**

**b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

## Appendix F: Participant-Rights

### Appendix F-3: State Grievance/Complaint System

**a. Operation of Grievance/Complaint System.** *Select one:*

- ( ) **No. This Appendix does not apply**
- (●) **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

**b. Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

Under the KanCare program, nearly all Medicaid services - including nearly all HCBS waiver services - will be provided through one of the three contracting managed care organizations. However, for those situations in which the participant is not a KanCare member, this grievance/complaint system applies. The Single State Medicaid Agency, Kansas Department of Health and Environment (KDHE), employs the fiscal agent to operate the consumer complaint and grievance system. (A description as to how KanCare members are informed that filing a grievance is not a prerequisite for a Fair Hearing is inluded at Appendix F.1.)

**c. Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Medical Assistance Customer Service Center (MACSC) at the fiscal agent is open to any complaint, concern, or grievance a consumer has against a Medicaid provider. The Consumer Assistance Unit staff logs and tracks all complaints, concerns, or grievances. If a provider has three complaints lodged against them, an investigation is initiated. KDHE and KDADS have access to this information at any time.

The MACSC transfers grievances to the Quality Assurance Team (QAT) on the date received. QAT has three (3) days to contact the grievant to acknowledge the grievance and thirty (30) days to complete the research and resolution. If more time is needed, QAT must request additional time from the state Program Manager.

## 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).

The state provides for the reporting and investigation of the following major and serious incidents: Abuse, Neglect, and Exploitation.

- Definitions of the types of critical events or incidents that must be reported:

Abuse: Any act or failure to act performed intentionally or recklessly that causes or is likely to cause harm to an adult including: 1) infliction of physical or mental injury; 2) any sexual act with an adult when the adult does not consent or when the other person knows or should know that the adult is incapable or resisting or

**c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The participant's chosen KanCare MCO provides information and resources to all participants and caregivers regarding strategies to identify, prevent, report, and correct any instances of potential Abuse, Neglect or Exploitation. Information and training on these subjects is provided by the MCOs to participants in the participant handbook, is available for review at any time on the MCO participant website, and is reviewed with each participant, by the care management staff responsible for service plan development, during the annual process of plan of care/service plan development. Depending upon the individual needs of each participant, additional training or information is made available and related needs are addressed in the participant's plan of care. The information provided by the MCOs is consistent with the state's abuse, neglect and exploitation incident reporting and management process (although the MCOs also have additional incident management information and processes beyond those regarding reporting/management of participant abuse, neglect and exploitation).

**d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The entity that receives reports of each type of critical event or incident: Kansas Department for Children and Families.

- The entity that is responsible for evaluating reports and how reports are evaluated.

Kansas Department for Children and Families (DCF) Intake Unit is responsible for receiving reports and determining if each report is screened in or out based on current policies identified in The Kansas Economic and Employment Support Manual [KEESM] for screening reports [12210]. If the report indicates criminal activity, local law enforcement is notified immediately.

**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 APS 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 KDHE, single state Medicaid agency, on an on-going basis, monthly and quarterly.

- The methods for overseeing the operation of the (AIR) system, including how data are collected, compiled, and used to prevent re-occurrence.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

**a. Use of Restraints.** *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

◉ **The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The state agency (or agencies) responsible for overseeing the use of restraint and ensuring that the state's safeguards are followed.

The Kansas Department for Aging and Disability Services (KDADS) has primary responsibility for overseeing this issue, and works with the KDHE, as part of the comprehensive QIS to monitor this service issue.

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

○ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

**i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

**b. Use of Restrictive Interventions.** *(Select one)*:

◉ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The state agency (or agencies) responsible for overseeing the use of restrictive interventions and ensuring that the state's safeguards are followed.

The Kansas Department for Aging and Disability Services (KDADS) has primary responsibility for overseeing this issue, and works with the KDHE, as part of the comprehensive QIS to monitor this service issue.

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

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

**i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

**ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

**c. Use of Seclusion.** *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The Kansas Department for Aging and Disability Services (KDADS) has primary responsibility for detection and oversight of unauthorized use of seclusion, 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.

KDADS conducts on-going, on-site, in-person reviews to educate and assess the participant's knowledge, ability and freedom from the use of seclusion. If it is determined that there is suspected un-authorized use, the KDADS Field Staff report immediately. Any areas of vulnerability would be identified for additional training and assurance of non-aversive methods

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

**i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (1 of 2)

*This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.*

**a. Applicability.** Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

**b. Medication Management and Follow-Up**

**i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Assisted Living Facilities, Residential Health Care Facilities, and Homes Plus operating in the state of Kansas are required to be licensed by the Kansas Department for Aging and Disability (KDADS). Regulations for these types of facilities require that a licensed nurse perform an assessment on each resident before the resident initially begins self-administration of medication, if the resident experiences a significant change of condition, and annually. This assessment is used to determine whether or not the resident can manage medications safely and accurately without staff assistance or if the facility will be responsible for administration of the resident's medications. Only licensed nurses and medication aides are authorized to administer and manage medications for which the facility has responsibility.

Regulations require that administration of each resident's medication be documented in the resident's record immediately before or following completion of the task. Licensed nurses and medication aides maintain record of the receipt and disposition of all medications managed by the facility for an accurate

**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.

First-line responsibility for monitoring participant medication regimens resides with the medical professionals who prescribe medications. Second-line responsibility for monitoring participant medication lies with the licensed pharmacist or licensed nurse responsible for completing a quarterly medication regimen review for each participant whose medication is managed by licensed facility staff.

The licensed pharmacist or licensed nurse is responsible for notifying the resident's medical care provider upon discovery of any variance identified in the medication regimen review that requires immediate action by the medical care provider. The licensed pharmacist must notify a licensed nurse within 48 hours of any variance identified in the resident's regimen review that does not require immediate action by the medical care provider and specify a time within which the licensed nurse must notify the resident's medical care provider.

## 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).

Following are excerpts from Assisted Living Facility, Residential Health Care Facility, and Home Plus regulations on self-administration of medications by residents:

(K.A.R. 26-41-205 and K.A.R. 26-42-205):

1. Any resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the

**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 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.

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

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

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.

(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 (KDADS) is the state's licensure and survey agency for adult care homes. An onsite review is completed for each assisted living facility, residential health care facility, and home plus within 15 months of any previous inspection to determine whether the adult care home is complying with applicable statutes, rules, and regulations relating to the health and safety of the residents, including medication administration. Each facility is provided with a survey report, which must be available to the public.

Only licensed nurses and certified medication aides are authorized to administer medications in adult care homes. Medication aides must pass a state-approved course on medication administration, receive a certificate from the KDHE, and be supervised by a licensed nurse. The credentials of these individuals are reviewed as part of the survey process.

## Appendix G: Participant Safeguards

### Quality Improvement: Health and Welfare

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

**a. Methods for Discovery: Health and Welfare**
***The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.*** *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

**i. Sub-Assurances:**

**a.** ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

**Performance Measures**

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

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

*are formulated, where appropriate.*

**Performance Measure:**
**Number and percent of unexpected deaths for which the appropriate follow-up measures were taken**
**N=Number of unexpected deaths for which the appropriate follow-up measures were taken**
**D=Number of unexpected deaths**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Record reviews**

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☑ **Other**<br>Specify:<br>Managed Care Organizations (MCOs) | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify:<br>KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency | ☑ **Annually** |

| | |
|---|---|
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of unexpected deaths for which review/investigation resulted in the identification of preventable causes N=Number of unexpected deaths for which review/investigation resulted in the identification of preventable causes D=Number of unexpected deaths**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Record reviews**

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☑ **Other**<br>Specify:<br>Managed Care Organizations (MCOs) | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify:<br>KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of waiver participants who received information on how to report suspected abuse, neglect, or exploitation N=Number of waiver participants who received information on how to report suspected abuse, neglect, or exploitation D=Number of waiver participants interviewed by QMS staff or whose records are reviewed**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Customer interviews and record reviews**

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval =<br>95% |
| ☐ **Other**<br>Specify: | ☑ **Annually** | ☑ **Stratified**<br>Describe Group:<br>Proportionate by MCO |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and** | **Frequency of data aggregation and** |
|---|---|

| **analysis** *(check each that applies):* | **analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☑ **Other**<br>Specify:<br>KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of unexpected deaths for which review/investigation followed the appropriate policies and procedures N=Number of unexpected deaths for which review/investigation followed the appropriate policies and procedures D=Number of unexpected deaths**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Record reviews**

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☑ **Other**<br>Specify:<br>Managed Care Organizations (MCOs) | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify:<br>KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**b.** ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

**Performance Measures**

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

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

**Performance Measure:**
**Number and percent of reported critical incidents requiring review/investigation where the State adhered to its follow-up measures N=Number of reported critical incidents requiring review/investigation where the State adhered to its follow-up measures D=Number of reported critical incidents**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Critical incident management system**

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

| | | |
|---|---|---|
| | | |
| ☑ **Other**<br>Specify:<br>Managed Care Organizations (MCO) | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify:<br>KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of participants' reported critical incidents that were initiated and reviewed within required time frames N=Number of participants' reported critical incidents that were initiated and reviewed within required time frames D=Number of participants reported critical incidents**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Critical Incident Management system**

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

| | | |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☑ **Other**<br>Specify:<br>Managed Care Organization (MCO) | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify:<br>KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance),*

*complete the following. Where possible, include numerator/denominator.*

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

**Performance Measure:**
**Number and percent of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver N=Number of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver D=Number of restraint applications, seclusion or other restrictive interventions**

**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**<br>Confidence Interval =<br>95% |
| ☑ **Other**<br>Specify:<br>Managed Care Organizations (MCO) | ☐ **Annually** | ☑ **Stratified**<br>Describe Group:<br>Proportionate by MCO |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify:<br>KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of unauthorized uses of restrictive interventions that were appropriately reported N=Number of unauthorized uses of restrictive interventions that were appropriately reported D=Number of unauthorized uses of restrictive interventions**

**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**<br>Confidence Interval =<br>95% |
| ☑ **Other**<br>Specify:<br>Managed Care Organizations (MCO) | ☐ **Annually** | ☑ **Stratified**<br>Describe Group:<br>Proportionate by MCO |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify:<br>KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**d.** ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

**Performance Measures**

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

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

**Performance Measure:**
**Number and percent of waiver participants who have a disaster red flag designation with a related disaster red flag designation with a related disaster backup plan N=Number of waiver participants who have a disaster red flag designation with a related disaster backup plan D=Number of waiver participants with a red flag designation**

**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**<br>Confidence Interval =<br>95% |
| ☑ **Other**<br>Specify: | ☐ **Annually** | ☑ **Stratified**<br>Describe Group: |

| | | |
|---|---|---|
| Managed Care Organization's | | Proportionate by MCO |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☑ **Other** Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State Operating Agency | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**Number and percent of waiver participants who received physical exams in accordance with State policies, N=Number of HCBS participants who received physical exams in accordance with State policies, D=Number of HCBS participants whose service plans were reviewed.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Record Reviews**

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

| | | |
|---|---|---|
| | | 95% |
| ☑ **Other**<br>Specify:<br>Managed Care Organizations (MCO) | ☐ **Annually** | ☑ **Stratified**<br>Describe Group:<br>Proportionate by MCO |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify:<br>KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

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

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 FE waiver providers to ensure adequate services and supports are in place. Additionally, KDADS conducts on-going, on-site, in-person reviews 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 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

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the State's 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-Community Services & Programs 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.

**ii. Remediation Data Aggregation**

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

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☑ **Other**<br>Specify:<br>KanCare Managed Care Organizations (MCOs) | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**

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

◉ **No**

○ **Yes**

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

## Appendix H: Quality Improvement Strategy (1 of 2)

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;
- 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 2)

### 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 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 Home and Community Based Services (HCBS) assurances and minimum standards of service.

Through KDADS's Quality Management Specialists (QMS) process, a statistically significant random sample of HCBS/FE participants are interviewed and is data collected for meaningful consumer feedback on the HCBS/FE program. KDADS reviews a statistically significant sample of participants for the HCBS/FE (KS.0303)Waiver population and the other affected waiver populations under the Quality Improvement Strategy (QIS). These include the Autism (KS.0476), Physical Disability(KS.30d), Serious Emotional Disturbance (KS.0320), Traumatic Brain Injury (KS.416d) and Technology Assisted

**ii. System Improvement Activities**

| **Responsible Party***(check each that applies):* | **Frequency of Monitoring and Analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☑ **Quality Improvement Committee** | ☑ **Annually** |
| ☑ **Other**<br>Specify:<br>KanCare Managed Care Organizations (MCOs) | ☐ **Other**<br>Specify: |

**b. System Design Changes**

**i.** Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

KDADS and the DHCF within KDHE 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 QMS process. Additional questions may be added to Participant Interview Protocols to obtain consumer feedback, or additional performance indicators and policy standards may be added to the HCBS Case File QMS Protocols. Results of these changes are collected, compiled, reviewed, and analyzed quarterly and annually.

Based on information gathered through the analysis of the QMS data and daily program administration, 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 MCO is sufficient, or if a system change is required.

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

Following is the process KDADS will use to identify and implement Quality Improvements and periodically evaluate the state's QIS:

The Operating Agency has developed Quality Management staff and an internal HCBS Quality Improvement Committee, comprised of Program, Quality Review, and Program Evaluation Staff, to meet quarterly to evaluate trends reflected in the HCBS Quality Review Reports and identify areas for improvement.

# 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 Home and Community Based Services (HCBS) provider is required to permit the Kansas Department of Health and Environment (KDHE), the Kansas Department for Aging and Disabilities (KDADS), their designee, and/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 HCBS 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 Managed Care Organizations (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:

# Appendix I: Financial Accountability

## Quality Improvement: Financial Accountability

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

**a. Methods for Discovery: Financial Accountability**

***State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.*** *(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=Number of clean claims that are paid by the managed care organization within the timeframes specified in the contract D=Total number of provider claims**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**DSS/DAI encounter data**

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

| *each that applies):* | *each that applies):* | |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☑ **Other**<br>Specify:<br>KanCare Managed Care Organizations (MCOs) | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify:<br>KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**

**Number and percent of provider claims that are coded and paid in accordance with the state's approved reimbursement methodology N=Number of provider claims that are coded and paid in accordance with the state's approved reimbursement methodology D= Total number of provider claims paid**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**DSS/DAI encounter data**

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☑ **Other**<br>Specify:<br>KanCare Managed Care Organizations (MCOs) | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify:<br>KanCare Managed Care Organizations (MCOs) participate in analysis of this measure's results as determined by the State operating agency | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**b.** ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

**Performance Measures**

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

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

**Performance Measure:**
**Number and percent of payment rates that were certified to be actuarially sound by the State's actuary and approved by CMS throughout the five year renewal cycle. N=number of payment rates that were certified to be actuarially sound by the State' actuary and approved by CMS D=Total number of capitation (payment) rates**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Rate-setting documentation**

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

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

The state established a interagency monitoring team to ensure effective interagency coordination as well as overall monitoring of MCO contract compliance. This work will be governed by the comprehensive state QIS for the KanCare program, a key component of which is the interagency monitoring team that engages program management, contract management and financial management staff of both KDHE and KDADS.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the State's 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 MCO contract, are included in a statewide comprehensive QIS which is regularly reviewed and adjusted. That plan is contributed to and monitored through a state interagency monitoring team, which includes program managers, contract managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.
State staff request, approve, and assure implementation of contractor corrective action planning and/or technical assistance to address non-compliance with performance standards as detected through on-site monitoring, survey results and other performance monitoring. These processes are monitored by both contract managers and other relevant state staff, depending upon the type of issue involved. Results are tracked consistent with the statewide QIS and the operating protocols of the interagency monitoring team.

**ii. Remediation Data Aggregation**

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

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>KanCare Managed Care Organizations (MCOs) | ☐ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and

remediation related to the assurance of Financial Accountability that are currently non-operational.

- (●) **No**
- ( ) **Yes**

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

## Appendix I: Financial Accountability

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

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

Under the KanCare comprehensive managed care program, capitation rates are established consistent with federal regulation requirements, by actuarially sound methods, which take into account utilization, medical expenditures, program changes and other relevant environmental and financial factors.

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

**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 consumer was eligible for the Medicaid waiver program during the month.

The state allows direct billing of claims through the MMIS portal.

## Appendix I: Financial Accountability

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

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

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

***Select at least one*:**

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

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

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

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

## Appendix I: Financial Accountability

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

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

A capitated payment is made to the MCOs for each month of Waiver eligibility. This is identified through KAECES , the State's eligibility system. The state also requires the MCOs to utilize the State's contracted Electronic Visit Verification for mandatory Waiver services. Those Waiver services are billed through EVV based on electronically verified provided services, connected to the participant's plan of care detailing authorized services. The MCOs reimburse only for delivery of services that are authorized on the participant's plan of care. All mandated services must be billed through the EVV system. Reviews to validate that services were in-fact provided as billed is part of the financial integrity reviews described above in Section I-1.

Individuals receiving EE waiver services must be determined Medicaid eligible prior to the date of service is initiated and that eligibility date reflected in the MMIS.

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

## Appendix I: Financial Accountability

### I-3: Payment (1 of 7)

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

○ **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**

○ **Payments for some, but not all, waiver services are made through an approved MMIS.**

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

○ **Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

⦿ **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

The MMIS Managed Care system assigns beneficiaries to one of the three MCOs. 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 MCOs.

## Appendix I: Financial Accountability

### I-3: Payment (3 of 7)

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

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

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

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

## Appendix I: Financial Accountability

### I-3: Payment (4 of 7)

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

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

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

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

## Appendix I: Financial Accountability

### I-3: Payment (5 of 7)

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

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

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

- ○ **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

## Appendix I: Financial Accountability

### I-3: Payment (6 of 7)

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

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

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

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

## Appendix I: Financial Accountability

### I-3: Payment (7 of 7)

**g. Additional Payment Arrangements**

**i. Voluntary Reassignment of Payments to a Governmental Agency.** *Select one:*

- ⊙ **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ○ **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

**ii. Organized Health Care Delivery System.** *Select one:*

- ⊙ **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the**

**provisions of 42 CFR §447.10.**

○ **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

**iii. Contracts with MCOs, PIHPs or PAHPs.** *Select one:*

○ **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.**

## 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 KDADS, through agreement with the Single State Medicaid Agency, 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 MMIS 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. DHCF-KDHE draws down federal Medicaid funds for all agencies based on the summary reports from iCSIS. Interfund transfers to the other state agencies are based on finalized fund summary reports. The full rate will be expended on capitation payments in the KanCare program.

☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (2 of 3)

**b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

- (●) **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
- ( ) **Applicable**

*Check each that applies:*

- [ ] **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- [ ] **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (3 of 3)

**c. Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

*Check each that applies:*

- [ ] **Health care-related taxes or fees**
- [ ] **Provider-related donations**
- [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

## Appendix I: Financial Accountability

### I-5: Exclusion of Medicaid Payment for Room and Board

**a. Services Furnished in Residential Settings.** *Select one:*

- ○ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ⊙ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

**b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

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.

The Actuary may collect financial information regarding room and board, the information is excluded from any recommendations regarding reimbursement rates.

## Appendix I: Financial Accountability

### I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

**Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.** *Select one:*

- ⊙ **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ○ **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

**a. Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- ⊙ **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ○ **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

**i. Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

***Charges Associated with the Provision of Waiver Services*** *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ **Nominal deductible**
- ☐ **Coinsurance**
- ☐ **Co-Payment**
- ☐ **Other charge**

*Specify:*

## Appendix I: Financial Accountability

## I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

**a. Co-Payment Requirements.**

**ii. Participants Subject to Co-pay Charges for Waiver Services.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

# Appendix I: Financial Accountability

## I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

**a. Co-Payment Requirements.**

**iii. Amount of Co-Pay Charges for Waiver Services.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

# Appendix I: Financial Accountability

## I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

**a. Co-Payment Requirements.**

**iv. Cumulative Maximum Charges.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

# Appendix I: Financial Accountability

## I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

**b. Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

# Appendix J: Cost Neutrality Demonstration

## J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

**Composite Overview.** Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

**Level(s) of Care: Nursing Facility**

| 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 | 8471.37 | 3238.67 | 11710.04 | 40485.32 | 3064.35 | 43549.67 | 31839.63 |
| 2 | 8511.84 | | 11758.09 | | | 44613.97 | 32855.88 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | 3246.25 | | 41508.84 | 3105.13 | | |
| 3 | 8555.87 | 3253.95 | 11809.82 | 42558.24 | 3146.60 | 45704.84 | 33895.02 |
| 4 | 8598.68 | 3261.76 | 11860.44 | 43634.17 | 3188.75 | 46822.92 | 34962.48 |
| 5 | 8642.36 | 3269.69 | 11912.05 | 44737.29 | 3231.61 | 47968.90 | 36056.85 |

## 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: |
| | | Nursing Facility |
| **Year 1** | **7038** | 7038 |
| **Year 2** | **7179** | 7179 |
| **Year 3** | **7322** | 7322 |
| **Year 4** | **7469** | 7469 |
| **Year 5** | **7618** | 7618 |

## Appendix J: Cost Neutrality Demonstration

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

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

Average Length of Stay was calculated by using the total days of waiver coverage for CY2013 (1/1/2013 - 12/31/2013) : 1,997,978, divided by the unduplicated number eligible: 7,038, or 284 ALOS.

## 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 for these estimates is as follows:

Factor D was estimated by utilizing data from the Kansas MMIS system and reflects the average HCBS waiver service cost and utilization for FE waiver participants for the calendar year 2013. This average expenditure was projected to Years 1 through 5 of the waiver with the assumption that these services would be provided under a managed care delivery system. Annual expenditures were projected at an average annual trend of 0.5%.

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' was estimated by utilizing data from the Kansas MMIS system and reflects the average acute care cost and utilization for FE waiver participants for the calendar year 2013. This average expenditure was projected to Years 1 through 5 of the waiver with the assumption that these services would be provided under a managed care delivery system. Annual expenditures were projected at an average annual trend of 0.25%.

Factor D' does not include the cost of Medicare Part D Prescribed Drugs. This is not a Medicaid cost and is not paid through the MMIS system.

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 was estimated by utilizing data from the Kansas MMIS system and reflects the average nursing facility cost and utilization for nursing facility members for the calendar year 2013. This average expenditure was projected to Years 1 through 5 of the waiver with the assumption that these services would be provided under a FFS delivery system. Annual expenditures were projected at an average annual trend of 2.5%.

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' was estimated by utilizing data from the Kansas MMIS system and reflects the average acute care cost and utilization for nursing facility members for the calendar year 2013. This average expenditure was projected to Years 1 through 5 of the waiver with the assumption that these services would be provided under a FFS delivery system. Annual expenditures were projected at an average annual trend of 1.3%.

## 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 | |
|---|---|
| **Financial Management Services** | |
| **Adult Day Care** | |
| **Assistive Technology** | |
| **Comprehensive Support - Provider Directed** | |
| **Comprehensive Support - Self-Directed** | |
| **Home Telehealth** | |
| **Medication Reminder** | |
| **Nursing Evaluation Visit** | |
| **Oral Health Services** | |
| **Personal Care Services - Provider Directed** | |
| **Personal Care Services - Self-Directed** | |
| **Personal Emergency Response** | |
| **Sleep Cycle Support - Self-Directed** | |
| **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 | Capi-tation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|---|
| **Financial Management Services Total:** | | | | | | | **3153828.12** |
| Financial Management Services | ✔ | 1 unit = 1 month | 3206 | 8.59 | 114.52 | **3153828.12** | |
| **Adult Day Care Total:** | | | | | | | **90491.11** |
| Adult Day Care | ✔ | 1 unit = 1 day (<5 hrs) | 45 | 97.95 | 20.53 | **90491.11** | |
| **Assistive Technology Total:** | | | | | | | **22496.89** |
| Assistive Technology | ✔ | 1 unit = 1 purchase | 23 | 1.06 | 922.76 | **22496.89** | |
| **Comprehensive Support - Provider Directed** | | | | | | | **154597.50** |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Total:** | | | | | | | |
| Comprehensive Support - Provider Directed | ✔ | 1 unit = 15 minutes | 19 | 2421.64 | 3.36 | **154597.50** | |
| **Comprehensive Support - Self-Directed Total:** | | | | | | | **70842.05** |
| Comprehensive Support - Self-Directed | ✔ | 1 unit = 15 minutes | 12 | 2202.80 | 2.68 | **70842.05** | |
| **Home Telehealth Total:** | | | | | | | **417636.18** |
| Home Telehealth - Installation/training | ✔ | 1 unit = 1 installation | 158 | 14.54 | 62.83 | **144340.62** | |
| Home Telehealth - Ongoing services | ✔ | 1 unit = 1 day | 194 | 234.79 | 6.00 | **273295.56** | |
| **Medication Reminder Total:** | | | | | | | **6581.27** |
| Medication Reminder | ✔ | 1 unit = 1 month | 78 | 5.32 | 15.86 | **6581.27** | |
| **Nursing Evaluation Visit Total:** | | | | | | | **1306.39** |
| Nursing Evaluation Visit | ✔ | 1 unit = 1 visit | 27 | 1.24 | 39.02 | **1306.39** | |
| **Oral Health Services Total:** | | | | | | | **0.00** |
| Oral Health Services | ✔ | 1 unit | 0 | 0.00 | 0.01 | **0.00** | |
| **Personal Care Services - Provider Directed Total:** | | | | | | | **32039870.74** |
| Attendant Care Services - Provider Directed - Level II | ✔ | 1 unit = 15 minutes | 1990 | 1409.81 | 3.58 | **10043768.40** | |
| Attendant Care Services - Provider Directed Level III | ✔ | 1 unit = 15 minutes | 2114 | 2858.13 | 3.41 | **20603516.06** | |
| Attendant Care Services - Provider Directed - Level I | ✔ | 1 unit = 15 minutes | 723 | 581.91 | 3.31 | **1392586.28** | |
| **Personal Care Services - Self-Directed Total:** | | | | | | | **22201197.56** |
| Personal Care Services - Self-Directed | ✔ | 1 unit = 15 minutes | 3069 | 2699.26 | 2.68 | **22201197.56** | |
| **Personal Emergency Response Total:** | | | | | | | **800586.05** |
| Personal Emergency Response - One time installation fee | ✔ | 1 unit = 1 installation | 304 | 1.03 | 55.51 | **17381.29** | |
| Personal Emergency Response - Ongoing services | ✔ | 1 unit = 1 month | 3567 | 8.72 | 25.18 | **783204.76** | |
| **Sleep Cycle Support - Self-Directed Total:** | | | | | | | **489799.48** |
| Sleep Cycle Support - Self-Directed | ✔ | 1 unit = 6 to 12 hours | 191 | 113.67 | 22.56 | **489799.48** | |
| **Wellness Monitoring Total:** | | | | | | | **172244.35** |
| Wellness Monitoring | ✔ | 1 unit = 1 visit | 1303 | 8.17 | 16.18 | **172244.35** | |

| | |
|---|---|
| **GRAND TOTAL:** | **59621477.68** |
| Total: Services included in capitation: | 59621477.68 |
| Total: Services not included in capitation: | |
| **Total Estimated Unduplicated Participants:** | **7038** |
| **Factor D (Divide total by number of participants):** | **8471.37** |
| Services included in capitation: | 8471.37 |
| Services not included in capitation: | |
| **Average Length of Stay on the Waiver:** | 284 |

# 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 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 2**

| Waiver Service/ Component | Capi-tation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|---|
| **Financial Management Services Total:** | | | | | | | **3231765.85** |
| Financial Management Services | ✔ | 1 unit = 1 month | 3270 | 8.63 | 114.52 | **3231765.85** | |
| **Adult Day Care Total:** | | | | | | | **92964.77** |
| Adult Day Care | ✔ | 1 unit = 1 day (<5 hrs) | 46 | 98.44 | 20.53 | **92964.77** | |
| **Assistive Technology Total:** | | | | | | | **22496.89** |
| Assistive Technology | ✔ | 1 unit = 1 purchase | 23 | 1.06 | 922.76 | **22496.89** | |
| **Comprehensive Support - Provider Directed Total:** | | | | | | | **155370.60** |
| Comprehensive Support - Provider Directed | ✔ | 1 unit = 15 minutes | 19 | 2433.75 | 3.36 | **155370.60** | |
| **Comprehensive Support - Self-Directed Total:** | | | | | | | **71196.45** |
| Comprehensive Support - Self-Directed | ✔ | 1 unit = 15 minutes | 12 | 2213.82 | 2.68 | **71196.45** | |
| **Home Telehealth Total:** | | | | | | | **428210.99** |
| Home Telehealth - Installation/training | ✔ | 1 unit = 1 installation | 161 | 14.62 | 62.83 | **147890.51** | |
| Home Telehealth - Ongoing services | ✔ | 1 unit = 1 day | 198 | 235.96 | 6.00 | **280320.48** | |
| **Medication Reminder Total:** | | | | | | | **6775.39** |
| Medication Reminder | ✔ | 1 unit = 1 month | 80 | 5.34 | 15.86 | **6775.39** | |
| **Nursing Evaluation Visit Total:** | | | | | | | **1365.70** |
| Nursing Evaluation Visit | ✔ | 1 unit = 1 visit | 28 | 1.25 | 39.02 | **1365.70** | |
| **Oral Health Services Total:** | | | | | | | **0.00** |
| Oral Health Services | ✔ | 1 unit | 0 | 0.00 | 0.01 | **0.00** | |
| **Personal Care Services - Provider Directed Total:** | | | | | | | **32841456.15** |
| Attendant Care Services - Provider Directed - Level II | ✔ | 1 unit = 15 minutes | 2030 | 1416.86 | 3.58 | **10296888.36** | |
| Attendant Care Services - Provider Directed Level III | ✔ | 1 unit = 15 minutes | 2156 | 2872.42 | 3.41 | **21117916.94** | |
| Attendant Care Services - Provider | ✔ | | | | | **1426650.85** | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Directed - Level I | | 1 unit = 15 minutes | 737 | 584.82 | 3.31 | | |
| **Personal Care Services - Self-Directed Total:** | | | | | | | **22755632.10** |
| Personal Care Services - Self-Directed | ✔ | 1 unit = 15 minues | 3130 | 2712.75 | 2.68 | **22755632.10** | |
| **Personal Emergency Response Total:** | | | | | | | **820182.74** |
| Personal Emergency Response - One time installation fee | ✔ | 1 unit = 1 installation | 310 | 1.03 | 55.51 | **17724.34** | |
| Personal Emergency Response - Ongoing services | ✔ | 1 unit = 1 month | 3638 | 8.76 | 25.18 | **802458.40** | |
| **Sleep Cycle Support - Self-Directed Total:** | | | | | | | **502564.61** |
| Sleep Cycle Support - Self-Directed | ✔ | 1 unit = 6 to 12 hours | 195 | 114.24 | 22.56 | **502564.61** | |
| **Wellness Monitoring Total:** | | | | | | | **176541.44** |
| Wellness Monitoring | ✔ | 1 unit = 1 visit | 1329 | 8.21 | 16.18 | **176541.44** | |

| | |
|---|---|
| **GRAND TOTAL:** | **61106523.68** |
| Total: Services included in capitation: | 61106523.68 |
| Total: Services not included in capitation: | |
| **Total Estimated Unduplicated Participants:** | **7179** |
| **Factor D (Divide total by number of participants):** | **8511.84** |
| Services included in capitation: | 8511.84 |
| Services not included in capitation: | |
| **Average Length of Stay on the Waiver:** | 284 |

## 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 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 3**

| Waiver Service/ Component | Capi-tation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|---|
| **Financial Management Services Total:** | | | | | | | **3315102.06** |
| Financial Management Services | ✔ | 1 unit = 1 month | 3335 | 8.68 | 114.52 | **3315102.06** | |
| **Adult Day Care Total:** | | | | | | | **95458.55** |
| Adult Day Care | ✔ | 1 unit = 1 day (<5 hrs) | 47 | 98.93 | 20.53 | **95458.55** | |
| **Assistive Technology Total:** | | | | | | | **23696.48** |
| Assistive Technology | ✔ | 1 unit = 1 purchase | 24 | 1.07 | 922.76 | **23696.48** | |
| **Comprehensive Support - Provider Directed Total:** | | | | | | | **164365.82** |
| Comprehensive Support - Provider Directed | ✔ | 1 unit = 15 minutes | 20 | 2445.92 | 3.36 | **164365.82** | |
| **Comprehensive Support** | | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **- Self-Directed Total:** | | | | | | | **71552.46** |
| Comprehensive Support - Self-Directed | ✔ | 1 unit = 15 minutes | 12 | 2224.89 | 2.68 | **71552.46** | |
| **Home Telehealth Total:** | | | | | | | **438781.20** |
| Home Telehealth - Installation/training | ✔ | 1 unit = 1 installation | 164 | 14.69 | 62.83 | **151367.52** | |
| Home Telehealth - Ongoing services | ✔ | 1 unit = 1 day | 202 | 237.14 | 6.00 | **287413.68** | |
| **Medication Reminder Total:** | | | | | | | **6898.62** |
| Medication Reminder | ✔ | 1 unit = 1 month | 81 | 5.37 | 15.86 | **6898.62** | |
| **Nursing Evaluation Visit Total:** | | | | | | | **1376.63** |
| Nursing Evaluation Visit | ✔ | 1 unit = 1 visit | 28 | 1.26 | 39.02 | **1376.63** | |
| **Oral Health Services Total:** | | | | | | | **0.00** |
| Oral Health Services | ✔ | 1 unit | 0 | 0.00 | 0.01 | **0.00** | |
| **Personal Care Services - Provider Directed Total:** | | | | | | | **33662083.79** |
| Attendant Care Services - Provider Directed - Level II | ✔ | 1 unit = 15 minutes | 2070 | 1423.95 | 3.58 | **10552323.87** | |
| Attendant Care Services - Provider Directed Level III | ✔ | 1 unit = 15 minutes | 2199 | 2886.78 | 3.41 | **21646779.64** | |
| Attendant Care Services - Provider Directed - Level I | ✔ | 1 unit = 15 minutes | 752 | 587.75 | 3.31 | **1462980.28** | |
| **Personal Care Services - Self-Directed Total:** | | | | | | | **23329774.56** |
| Personal Care Services - Self-Directed | ✔ | 1 unit = 15 minutes | 3193 | 2726.32 | 2.68 | **23329774.56** | |
| **Personal Emergency Response Total:** | | | | | | | **840541.03** |
| Personal Emergency Response - One time installation fee | ✔ | 1 unit = 1 installation | 316 | 1.04 | 55.51 | **18242.81** | |
| Personal Emergency Response - Ongoing services | ✔ | 1 unit = 1 month | 3711 | 8.80 | 25.18 | **822298.22** | |
| **Sleep Cycle Support - Self-Directed Total:** | | | | | | | **515432.61** |
| Sleep Cycle Support - Self-Directed | ✔ | 1 unit = 6 to 12 hours | 199 | 114.81 | 22.56 | **515432.61** | |
| **Wellness Monitoring Total:** | | | | | | | **181005.66** |
| Wellness Monitoring | ✔ | 1 unit = 1 visit | 1356 | 8.25 | 16.18 | **181005.66** | |

| | |
|---|---|
| **GRAND TOTAL:** | **62646069.46** |
| Total: Services included in capitation: | 62646069.46 |
| Total: Services not included in capitation: | |
| **Total Estimated Unduplicated Participants:** | **7322** |
| **Factor D (Divide total by number of participants):** | **8555.87** |
| Services included in capitation: | 8555.87 |
| Services not included in capitation: | |
| **Average Length of Stay on the Waiver:** | 284 |

## 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 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 4**

| Waiver Service/ Component | Capi-tation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|---|
| **Financial Management Services Total:** | | | | | | | **3397286.19** |
| Financial Management Services | ✔ | 1 unit = 1 month | 3402 | 8.72 | 114.52 | **3397286.19** | |
| **Adult Day Care Total:** | | | | | | | **97982.30** |
| Adult Day Care | ✔ | 1 unit = 1 day (<5 hrs) | 48 | 99.43 | 20.53 | **97982.30** | |
| **Assistive Technology Total:** | | | | | | | **23696.48** |
| Assistive Technology | ✔ | 1 unit = 1 purchase | 24 | 1.07 | 922.76 | **23696.48** | |
| **Comprehensive Support - Provider Directed Total:** | | | | | | | **165187.68** |
| Comprehensive Support - Provider Directed | ✔ | 1 unit = 15 minutes | 20 | 2458.15 | 3.36 | **165187.68** | |
| **Comprehensive Support - Self-Directed Total:** | | | | | | | **77902.59** |
| Comprehensive Support - Self-Directed | ✔ | 1 unit = 15 minutes | 13 | 2236.01 | 2.68 | **77902.59** | |
| **Home Telehealth Total:** | | | | | | | **450374.17** |
| Home Telehealth - Installation/training | ✔ | 1 unit = 1 installation | 168 | 14.76 | 62.83 | **155798.29** | |
| Home Telehealth - Ongoing services | ✔ | 1 unit = 1 day | 206 | 238.33 | 6.00 | **294575.88** | |
| **Medication Reminder Total:** | | | | | | | **7108.45** |
| Medication Reminder | ✔ | 1 unit = 1 month | 83 | 5.40 | 15.86 | **7108.45** | |
| **Nursing Evaluation Visit Total:** | | | | | | | **1425.79** |
| Nursing Evaluation Visit | ✔ | 1 unit = 1 Visit | 29 | 1.26 | 39.02 | **1425.79** | |
| **Oral Health Services Total:** | | | | | | | **0.00** |
| Oral Health Services | ✔ | 1 unit | 0 | 0.00 | 0.01 | **0.00** | |
| **Personal Care Services - Provider Directed Total:** | | | | | | | **34510170.92** |
| Attendant Care Services - Provider Directed - Level II | ✔ | 1 unit = 15 minutes | 2112 | 1431.07 | 3.58 | **10820263.03** | |
| Attendant Care Services - Provider Directed Level III | ✔ | 1 unit = 15 minutes | 2243 | 2901.21 | 3.41 | **22190281.84** | |
| Attendant Care Services - Provider Directed - Level I | ✔ | 1 unit = 15 minutes | 767 | 590.69 | 3.31 | **1499626.05** | |
| **Personal Care Services - Self-Directed Total:** | | | | | | | **23916365.96** |
| Personal Care Services | ✔ | | | | | **23916365.96** | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| - Self-Directed | | 1 unit = 15 minutes | 3257 | 2739.95 | 2.68 | | |
| **Personal Emergency Response Total:** | | | | | | | **862107.67** |
| Personal Emergency Response - One time installation fee | ✔ | 1 unit = 1 installation | 323 | 1.04 | 55.51 | **18646.92** | |
| Personal Emergency Response - Ongoing services | ✔ | 1 unit = 1 month | 3785 | 8.85 | 25.18 | **843460.76** | |
| **Sleep Cycle Support - Self-Directed Total:** | | | | | | | **528403.48** |
| Sleep Cycle Support - Self-Directed | ✔ | 1 unit = 6 to 12 hours | 203 | 115.38 | 22.56 | **528403.48** | |
| **Wellness Monitoring Total:** | | | | | | | **185504.83** |
| Wellness Monitoring | ✔ | 1 unit = 1 visit | 1383 | 8.29 | 16.18 | **185504.83** | |

| | |
|---|---|
| **GRAND TOTAL:** | **64223516.52** |
| Total: Services included in capitation: | 64223516.52 |
| Total: Services not included in capitation: | |
| **Total Estimated Unduplicated Participants:** | **7469** |
| **Factor D (Divide total by number of participants):** | **8598.68** |
| Services included in capitation: | 8598.68 |
| Services not included in capitation: | |
| **Average Length of Stay on the Waiver:** | 284 |

# 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 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 5**

| Waiver Service/ Component | Capi-tation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|---|
| **Financial Management Services Total:** | | | | | | | **3481087.34** |
| Financial Management Services | ✔ | 1 unit = 1 month | 3470 | 8.76 | 114.52 | **3481087.34** | |
| **Adult Day Care Total:** | | | | | | | **100516.52** |
| Adult Day Care | ✔ | 1 unit = 1 day (<5 hrs) | 49 | 99.92 | 20.53 | **100516.52** | |
| **Assistive Technology Total:** | | | | | | | **24914.52** |
| Assistive Technology | ✔ | 1 unit = 1 purchase | 25 | 1.08 | 922.76 | **24914.52** | |
| **Comprehensive Support - Provider Directed Total:** | | | | | | | **174314.25** |
| Comprehensive Support - Provider Directed | ✔ | 1 unit = 15 minutes | 21 | 2470.44 | 3.36 | **174314.25** | |
| **Comprehensive Support - Self-Directed Total:** | | | | | | | **78292.10** |
| Comprehensive Support - Self-Directed | ✔ | 1 unit = 15 minutes | 13 | 2247.19 | 2.68 | **78292.10** | |
| **Home Telehealth Total:** | | | | | | | **461235.12** |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Home Telehealth - Installation/training | ✔ | 1 unit = 1 installation | 171 | 14.84 | 62.83 | **159439.92** | |
| Home Telehealth - Ongoing services | ✔ | 1 unit = 1 day | 210 | 239.52 | 6.00 | **301795.20** | |
| **Medication Reminder Total:** | | | | | | | **7234.06** |
| Medication Reminder | ✔ | 1 unit = 1 month | 84 | 5.43 | 15.86 | **7234.06** | |
| **Nursing Evaluation Visit Total:** | | | | | | | **1437.11** |
| Nursing Evaluation Visit | ✔ | 1 unit = 1 visit | 29 | 1.27 | 39.02 | **1437.11** | |
| **Oral Health Services Total:** | | | | | | | **0.00** |
| Oral Health Services | ✔ | 1 unit | 0 | 0.00 | 0.01 | **0.00** | |
| **Personal Care Services - Provider Directed Total:** | | | | | | | **35377809.95** |
| Attendant Care Services - Provider Directed - Level II | ✔ | 1 unit = 15 minutes | 2154 | 1438.22 | 3.58 | **11090574.65** | |
| Attendant Care Services - Provider Directed Level III | ✔ | 1 unit = 15 minutes | 2288 | 2915.72 | 3.41 | **22748680.70** | |
| Attendant Care Services - Provider Directed - Level I | ✔ | 1 unit = 15 minutes | 783 | 593.64 | 3.31 | **1538554.60** | |
| **Personal Care Services - Self-Directed Total:** | | | | | | | **24515635.80** |
| Personal Care Services - Self-Directed | ✔ | 1 unit = 15 minutes | 3322 | 2753.65 | 2.68 | **24515635.80** | |
| **Personal Emergency Response Total:** | | | | | | | **883461.55** |
| Personal Emergency Response - One time installation fee | ✔ | 1 unit = 1 installation | 329 | 1.05 | 55.51 | **19175.93** | |
| Personal Emergency Response - Ongoing services | ✔ | 1 unit = 1 month | 3861 | 8.89 | 25.18 | **864285.62** | |
| **Sleep Cycle Support - Self-Directed Total:** | | | | | | | **541523.92** |
| Sleep Cycle Support - Self-Directed | ✔ | 1 unit = 6 to 12 hours | 207 | 115.96 | 22.56 | **541523.92** | |
| **Wellness Monitoring Total:** | | | | | | | **190038.95** |
| Wellness Monitoring | ✔ | 1 unit = 1 visit | 1410 | 8.33 | 16.18 | **190038.95** | |

| | |
|---|---|
| **GRAND TOTAL:** | **65837501.20** |
| Total: Services included in capitation: | 65837501.20 |
| Total: Services not included in capitation: | |
| **Total Estimated Unduplicated Participants:** | **7618** |
| **Factor D (Divide total by number of participants):** | **8642.36** |
| Services included in capitation: | 8642.36 |
| Services not included in capitation: | |
| **Average Length of Stay on the Waiver:** | 284 |