



Kansas Money Follows the Person Operational Protocol

**Submitted by:
Kansas Department of Social & Rehabilitative Services
Kansas Department on Aging
Kansas Health Policy Authority**

*KHPA Letterhead would not reproduce- signature on file. A hard copy is available upon request.

February 12, 2008

Ms. Kate King, CMS Project Officer
Centers for Medicare and Medicaid Services
Center for Medicaid and State Operations
Disabled and Elderly Health Programs Group
Mail Stop: S2-14-26, 7500 Security Boulevard
Baltimore, MD 21244-1860

Re: Money Follows the Person Operational Protocol Submission
CMS Grant No. 1LICMS030166

Dear Ms. King:

The Kansas Health Policy Authority (KHPA), the single state Medicaid agency for Kansas, on behalf of Kansas Department of Social and Rehabilitative Service (SRS), the funded lead agency for this project, is pleased to electronically submit *The Kansas Money Follows the Person Demonstration Operational Protocol*. Kansas will begin implementation of the demonstration on July 1, 2008, upon approval of the operational protocol by the Centers for Medicare and Medicaid Services (CMS).

This demonstration project is the result of a partnership between three state agencies: Kansas Health Policy Authority (KHPA), Kansas Social and Rehabilitative Services (SRS), and the Kansas Department of Aging (KDOA). Our operational protocol is a product of extensive work by state employees in conjunction with a diverse group of committed stakeholders. We feel confident our Operational Protocol represents a plan that is the result of meaningful participation by consumers, service providers, and advocacy organizations that are invested in successful implementation of Money Follows the Person in Kansas.

Follow-up questions or additional information can be requested from Frank Stahl, Assistant Director of Community Supports and Services, and Angie Reinking, MFP Project Director, who are serving as leads on this project. Mr. Stahl can be reached at (785) 296-6140 or by e-mail at frank.stahl@srs.ks.gov. Ms. Reinking can be reached at (785) 296-7744 or by e-mail at angie.reinking@srs.ks.gov.

Sincerely

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Bill McDaniel,
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Section I, Part A- Project Introduction

Introduction to the Kansas MFP Demonstration

Kansas has a very diverse Long Term Care System, the strength of which arises from the strength of the voice of consumer advocates. The services provided result from this advocacy and the quality of the services is to their credit as well. Kansas celebrates a strong cultural heritage of consumer commitment that ensures the voice of consumers is heard in the Governors' office, on the legislative floor and in the state departments responsible for administration of state programs. Consumers hold major responsibility for the design, implementation, monitoring, and evaluation of the Kansas LTC system.

In collaboration with the appointed Money Follows the Person Steering Committee, SRS and KDOA will develop, guide and monitor the MFP Demonstration project in Kansas. While ensuring consumer involvement could be a considerable barrier for some states, Kansas has a long history of collaboration with stakeholders. Gathering input, understanding consumer concepts, and having continuous consumer involvement is Kansas' natural way of doing business.

The "Money Follows the Person" demonstration project provides an additional opportunity to ensure that all Kansans have the opportunity to live and work in settings of their choice, and for consumers / stakeholders to partner with the state agencies to ensure no one is neglected, abused, placed in unhealthy living situations, or not assured access to a qualified, well trained, and supported community workforce. A diverse group of individuals, organizations and agencies have been brought together in the development of this *Operational Protocol*. As a result the partnership between provider networks, advocacy groups, and state agencies has been strengthened and will continue to be nurtured by the project director in order to achieve the goals of the demonstration. While philosophical differences may remain, key stakeholders have come together to create a plan for MFP processes that everyone has agreed to. The process of working together to find this agreement is an exciting first 'success' of this project. Kansas is now poised to continue to build on this success in order to assure Kansas citizens experience informed choice about the range of service options, including community living options. Ultimately, greater access to choices for service and supports will further reduce the institutional bias in Kansas.

History

Kansas first implemented a state Money Follows the Person Project in SFY04 in response to a legislative proviso in the State's appropriation bill. The proviso has since been renewed annually. The program allowed for up to 75 persons (80 since SFY '07) living in nursing homes to be transferred to the HCBS/Frail Elderly or Physically Disabled (HCBS/PD) waiver programs upon relocation to the community. Funding allocated to the nursing home budget is transferred to the applicable waiver program from the month the transfer occurs through the end of the state fiscal year. A total of 117 persons transferred from nursing facilities into community programs as a result of this initiative. One of the barriers to transitioning more individuals is the lack of funding for start up costs when someone returns to the community via our state legislative proviso. Centers for Independent Living (CIL'S) provided pre and post move-out transition plan development and implementation without state or Medicaid reimbursement. This issue is

addressed as part of the MFP demonstration project via the addition of a demonstration service titled “transition service”. Furthermore, it is anticipated that our use of MDS data to target potential MFP candidates will contribute to an increased number of people transitioning back into the community. We are pleased that the MFP project will allow us to serve a larger number of people than has been authorized in the past through our state MFP proviso. We will continue to utilize the state proviso for individuals who have been in the nursing facility for three months or more but less than 6 months. Advocacy efforts are underway to have the current limit of persons in the state proviso suspended. However, the outcome of these efforts has no bearing on our financial authority to serve persons who qualify for our federal MFP project.

Additionally, Kansas utilizes money follows the person for all persons served in the State operated ICFs/MR by statute and in practice. The Community Integration Project (CIP) has expanded from the original scope to include all persons living in private ICFs/MR that are closing beds. Kansas has been successful in closing one major state operated ICF/MR and five large bed private ICFs/MR in the past 12 years. Kansas closed 120 beds in small to medium bed ICFs/MR through the CIP project. By all measures the CIP project has been successful in rebalancing the LTC budget for persons with developmental disabilities and ensuring that Kansas’ disabled citizens are provided services in community settings of their choice.

SRS and KDOA will work in collaboration with consumers, advocacy organizations, service providers, and community partners to further the proposed MFP Demonstration beyond the 5 year grant period, to amend the current HCBS waivers for persons who are elderly, traumatic brain injured, physically disabled and those with mental retardation/developmental disabilities to include transition services. In addition, Kansas will work to identify the regulatory barriers which prevent our network of nursing facilities from contributing to increased community capacity. Kansas has nursing facilities in each of its 105 counties. This network is a potential resource for increasing the community capacity of home and community services. This project will explore building upon and repurposing these existing resources to enhance the availability of home and community based services and supports. The community capacity task team will be charged with ongoing efforts in this area. SRS and KDOA will cooperatively appoint a MFP steering committee that will address the implementation structure, strategy and design.

Populations

1.Rebalancing; increasing use of HCBS

The Kansas Money Follows the Person Demonstration will be a five year demonstration with a total budget of \$ 53,458,188

The state will achieve rebalancing through a 8 percentage point shift of HCBS spending over institutional costs by the end of the project. The target population for the demonstration is cross-age and cross-disability, including: elderly, physically disabled, persons with traumatic brain injury and individuals in ICF/MR settings, both private and public, and people residing in State Mental Retardation Hospitals. The demonstration has a projected reduction in LTC expenditures of over 20 million dollars.

The state has targeted 220 of the current 267 private ICFs/MR licensed beds (252 filled) for closure. The closure is voluntary; however closure incentives are built into the demonstration project.

Rebalancing Goals:

1. Total “enhanced” FMAP for demonstration services is \$38,480,106. This represents the total of Qualified HCBS services at \$26,484,594 plus Demonstration services at \$11,995,914. ;
2. Shift in LTC funding on Institutions from 47% to 39%. HCBS funding will shift from 53% to 61%. ; and,
3. By shifting LTC costs Kansas will realize an approximated \$20.3 million savings to serve the same number of persons in the HCBS programs over institutional care.

Our 8 % shift in funding to community over institution by the end of the project is a result of the closure of private ICF/MR beds. No beds will be closing in nursing facilities or at our state hospital (SMRH) so therefore the shift is somewhat modest. At this time there is not sufficient support for closure of beds in nursing facilities. Additionally, we are currently experiencing an increase in requests for admission to our State Mental Retardation Hospital (SMRH). A primary goal of this demonstration project is to identify the additional supports needed that will allow persons with developmental disabilities to successfully maintain community placements. Our benchmarks address this issue with specific goals related to reducing requests for admission to our (SMRH).

The state will provide varying supplemental services during the demonstration period. Variance in services is based on the HCBS service the person will receive; differences are unavoidable due to the vast difference of need between groups and the desire to use portions of the enhanced FMAP as closure incentive dollars and to provide extremely expensive services to individuals with offender behaviors in the MR/DD population. The private ICF/MR closure incentive dollars are paid with state general funds. The demonstration service *Therapeutic Support* is designed to improve community capacity to serve individuals with developmental disabilities or traumatic brain injury who have intense support needs and/or offender behaviors.

Consumers were involved throughout the initial application planning process. In addition, a steering committee comprised of at least 51% consumer members has been formed to guide and monitor demonstration activities.

The project maintains a strong emphasis on independent living (self-direction). During the demonstration independent living counselors will support identified individuals in the nursing facilities to determine their desire to return to their community homes and to help coordinate transition services and support needs to successfully return to the community. Additionally the project will utilize the K-PASS developed ‘Self-direction Tool Kit’ as the basic training tool for use by those entering HCBS services. This tool kit provides guidance on all aspects of self-direction: interviewing, hiring, training, maintaining, and firing attendants.

2. MFP- Reduction in Barriers

As a result of recent amendments to all of the 1915 (c) Waivers operated in Kansas, the addition of a 1915 (b) Waiver, this Money Follows the Person demonstration grant , the ADRC (Aging Disabled Resource Center) grant, the PRTF (Psychiatric Residential Treatment Facility) grant and the Real Choice – Systems Transformation grant, Kansas will have expanded community services to additional population groups, added new and innovative services, expanded the coverage of existing

services, and conducted a comprehensive review of the complete Long Term Care system in Kansas. By coordinating the activities and results of all these initiatives, the MFP demonstration project will create meaningful choice and opportunities for independent living for all Kansans.

MFP will open institutional doors to Kansans who desire to return to the community. Kansas will utilize the innovative demonstration services proposed to enhance community based waiver services, thereby ensuring greater access, a wider array of services, enhanced community capacity, a trained workforce, and a strong focus on maintenance of a community system as the first line of service, rather than an alternative service. More importantly, MFP will allow Kansas to specifically target individuals who did not benefit from diversion activities and are currently receiving an institutional level of care but could be supported to live independently in community based services. Many individuals currently residing in our qualified institutions entered these settings due to a lack of knowledge of community based services or a lack of community capacity to support these individuals. Through this demonstration we can focus on offering services to people who can now benefit from an expanded array of services and improved community capacity.

Kansas will create communities statewide that understand the needs of an aging and disabled population and that will have the resources available to meet those needs. Persons will not age out of their home communities or be “too disabled” to live in their own homes. Kansas communities will be supported and trained to prevent institutionalization and to support development of community bonds.

Strong advocacy efforts, supported by state agencies, will ensure that the current “limited” MFP legislative proviso will be expanded to assure that any Kansan who is institutionalized can utilize his or her institutional service funding to return to the community.

3. Continuity of Service-

No new waivers will be created; all MFP participants will transition from a qualified institution back to the community with long-term services and supports provided through services that mirror our existing 1915(c) Medicaid waivers. Participants will be served under our demonstration authority for 365 days and upon day 366 their services will transfer to the 1915(c) waiver. Services will continue for MFP participants as long as they desire to remain in the community and meet the eligibility criteria.

This is described in further detail in section B, item # 10)

4. Quality Strategies and Continuous Quality Improvement

The approved Kansas Quality Management Strategy for all currently operated waivers that will be utilized to serve demonstration participants will be enhanced to include 100% monitoring of all individuals transitioning out of institutional settings during the first year in the community. This is an enhancement over current random sampling techniques.

The data will be evaluated and trended quarterly to provide early detection of health, safety, life quality, and dissatisfaction issues. The data developed will be used for designing and implementing the continuation of this project into future years.

1. Case Study

Provide a detailed description, from a demonstration participant's perspective, of the overall program and the interventions for transition and rebalancing that the State proposes to use under the demonstration. The case study should walk the reader through every step of the proposed processes. These steps include, but are not limited to, the initial process of participant identification, processes that will occur prior to transition, those processes employed during the actual transition into community life and those processes that will be utilized when the individual has been fully transitioned into a home and community-based program.

Case Study 1 - Sally

Sally is a 59 year old woman who currently resides in a nursing facility. Sally has a history of stroke and has functional limitations that meet the qualifications for the Physical Disabilities (PD) waiver. She was recently hospitalized as a result of a third stroke and was not able to return home because her support needs had increased. She felt she would not be able to care for herself to the extent that she was able to prior to her hospitalization. She hoped that she would become stronger as a result of therapy, but it was clear that she would never be as strong as she was before her hospitalization. Almost eight months after she entered the nursing home, her prospect of ever returning home was unlikely. Sally has been receiving Medicaid benefits for the last two months. Upon entering the facility Sally had a functional eligibility score of 78 and needs assistance with Activities of Daily Living (ADL's) and Instrumental Activities of Daily Living (IADL's). This eligibility score is determined using a Universal Assessment Instrument (UAI) which assesses an individual's ability to complete ADL's and IADL's and determines eligibility for the PD waiver.

Identification

Sally thought that there were programs for people who wanted to move home, but she was not sure who to contact. One day she received a letter describing a program called Money Follows the Person and that a team of people would like to meet with her to discuss community living options. The letter explained that she was being contacted because she expressed a desire to return to the community. (based on her responses to MDS questions at the facility). * A copy of the letter also went to the state ombudsman office, the nursing facility where Sally resides and if she has a guardian it would go to the guardian as well. The letter also informed Sally of her right to decline a meeting with the Community Bridge Building team (CBB team) and informed her who was part of the team and that she could invite anyone else she wanted to attend. The CBB team includes: resident, nursing facility social worker or transition staff, Area Agency on Aging representative, Center for Independent Living representative, a legal representative (if resident has one), and anyone else the resident would like to invite. A state long term care ombudsman volunteer went to visit Sally to verify receipt of the letter and see if Sally had any questions. Sally stated that she was unsure about how she could move back home but wanted to learn how this program might make this possible. A meeting was scheduled with the team and Sally was assured that her daughter could also attend. The letter was generated by the Kansas Department on Aging as a result of an MDS data query. Further information on the use of MDS data, letters to potential MFP candidates, & community bridge building teams can be found in section B-1 Participant Recruitment & Enrollment.

* Sally also could have learned about or been referred to MFP through other means including: nursing facility staff, a friend or family member, long term care ombudsman staff, or via outreach & marketing efforts, which could lead to a self referral.

At the team meeting Sally talked about the difficulty she was now having taking care of herself and how scared she was about having more health setbacks. Sally's daughter was able to attend the meeting and they talked about how much Sally wanted to return home, the help she needed, and some of the barriers in her home. Sally spoke of how thankful she is that she still has her house, which is paid for and that her children have helped her to pay the property tax. Her family is very aware that Sally has dreamed of going back home and knows that having a house is a huge asset to Sally. Various members of the team discussed what services are available to meet her needs including attendant care to help her bathe and that her home could be modified to accommodate her wheelchair. Sally stated she would like to continue to work on going home, even though she was nervous about the idea. The team member who represents the HCBS waiver for which Sally would qualify agreed to set up another meeting with Sally where they could discuss her options in more detail. Sally has no difficulty communicating via telephone and expressed a desire to have a reminder call the day before future meetings.

Pre-transition Planning

The transition coordinator (TC) met with Sally to further assess her needs and discuss the possibility for transition. The transition coordinator indicated she would continue to contact the nursing home discharge planner to ensure that they were all working together. During the conversation, the TC explained Sally's rights and responsibilities under the MFP program and explained the services included in the MFP Demo. Sally was able to understand and gave her consent to participate in the MFP Demo. An informed consent form was signed by Sally. Sally indicated that she wanted the TC to be able to talk with her daughter to help her explain everything to her daughter. A release of information form was signed that allowed the TC to share the elements of transition planning that Sally indicated. The TC explained that how much is shared continues to be Sally's choice and that their personal conversations about family dynamics and history would not get discussed with her daughter.

The transition coordinator worked with Sally to talk about any barriers to coming home and to continue to explain all aspects of the program. Some items will be addressed via the MFP program and others involved contacting other community agencies for assistance. The TC let Sally decide whether she wanted to follow up on community referrals or whether she would like the TC to assist her in making the calls. They also discussed that Sally could choose to get her attendant care services through an agency that would arrange for workers or she could self-direct her services, which would allow her to hire and select her own staff. Sally felt that hiring her own staff sounded overwhelming but that in the future she might think about self-directing part of her services. The TC assured Sally that this decision was hers and that she could choose to self-direct all or part of her services at any time. The TC also offered to refer Sally to a peer counseling program that would connect her with someone else who had lived in a facility and then moved back home. Sally liked this idea and looked forward to talking to someone who had experienced a similar transition. The peer counseling is offered by the local Center for Independent Living and is not an MFP funded service.

Transition Planning

As barriers were addressed Sally became increasingly hopeful about moving back home. A case manager worked with Sally to assess her needs in order to assure the supports that Sally needs will be in place upon transition. The case manager has received state sponsored HCBS waiver training and has attended the required training on the MFP Demo provided by the state. The case manager

has 10 years of experience in case management in HCBS waiver programs. The case manager made arrangements to meet with Sally and her daughter at Sally's home so they could assess her home situation. A physical therapist from the nursing home was also scheduled to attend. While at her home, Sally described the kinds of help she felt would allow her to be successful at meeting her goals for living at home and being able to participate in family and community activities again. With her daughters help, Sally was able to get into her house but she will need a ramp to enter independently. The physical therapist reviewed the physical space and asked Sally to demonstrate how she was able to move about in her home. In many small communities it is not uncommon that the nursing facility staff goes above and beyond their job duties in order to assist the resident. While this additional service outside the facility may not be available in all communities, it will be a benefit to individuals in the communities where nursing facility staff are able to provide this additional support.

The case manager and Sally came up with a plan of care that included personal care, delivery of a noon meal, a personal response system and home modifications that would make her home functional for her. The physical therapist recommended a ramp and grab bars by the toilet and in the shower. Sally would also be receiving the demo service *Transition Service* that would help Sally pay to get her water and gas deposits paid for at home. Sally's daughter said she would call her mother daily and visit two to three times a week, bringing Sally's grandchildren for visits as often as possible. Sally was pleased with the plan and indicated her agreement with the plan by signing it. The care plan was submitted to the state Medicaid agency, approved and funding arranged. Information about Sally was also submitted to the MFP Demo Project Director for review and incorporation into the MFP Demo database.

Time line for Transition

Sally met with the community bridge building team within 30 days of receiving the letter about the opportunity to discuss community living with this team. At this meeting Sally made an informed choice to participate in Money Follows the Person. She was then referred to a transition coordinator who came to meet with Sally and discuss the possibility of transition. Though Sally had access to up to 4 months of transition coordination service she only needed 2 months (60 days) of this service. She then worked with a case manager for 2 months to complete her plan of care and arrange for her community based services. Sally moved out of the nursing facility 5 months after first receiving a letter about the Money Follows the Person program.

Transition

On the day that Sally moved home, the case manager had arranged for a van to give Sally a ride and followed her from the nursing home. The ramp and grab bars were in place and her daughter was waiting for her. The provider, who installed the ramp & grab bars, provided this service in advance of Sally's transition, with the understanding that they would not be able to bill for the service until Sally moves home. Personal care services were set to be provided by the agency chosen by Sally. The nurse from the home health agency came that first day to make sure that everything was in place. The young woman who was assigned to provide Sally's attendant care was also there and seemed very capable and pleasant. Sally was a little nervous at first and made sure her personal response unit worked. She also made sure she had the phone number for her case manager on speed dial, but she did not need to call. The case manager called a couple of times during Sally's first month at home and visited at the end of the month to review Sally's satisfaction with the services and determine if her needs were being met. Sally entered the MFP demonstration on her first day in the community. She is eligible for 365 days of participation under the demonstration project. On day 366 Sally will stop receiving services under the MFP demo and will transition to the HCBS Physical Disabilities waiver.

During the first year in the community, Sally's case manager contacted her each month, either by phone or in person. The case manager also checked in several times with the home health agency to see if everything was working out. The case manager continued to review with Sally her ability to access public transportation in order to get to medical appointments and social events. Sally continued to learn about various clubs & social opportunities from her peer counselor. (informal support from CIL). Over the course of the year, Sally had to implement the back-up plan once when the personal care worker had car trouble. She was able to contact the home health agency who began working to arrange a different worker. In the meantime Sally called her case manager who reminded her of her personalized emergency backup plan and that a copy was posted by her chair. After reviewing her plan Sally decided to call her daughter who offered to come over and provide support that day. Sally contacted the home health agency and let them know she did not need a different worker. Her regular worker returned to work the next day.

Over the course of the year, Sally had another mild stroke that required a brief hospitalization. Her daughter contacted the case manager who visited Sally in the hospital and worked with Sally and the hospital discharge planner to develop a plan that increased services in the home so that Sally would not have to go to a nursing home upon discharge. Sally was glad to be able to go directly home and have therapy there rather than in the nursing home.

At the end of the year in the MFP Demo, Sally's services were automatically switched to waiver funding. If her case manager had not come to tell her that she was no longer in the MFP Demo, she would not have been aware based on any changes in her services and support. A functional eligibility assessment was performed by her case manager. Sally continued to receive the services she needed and her case manager continued regular contacts to see how things were going and to address any additional needs.

Although Sally's situation is somewhat straightforward because she had a home to move back to, other individuals transitioning from nursing homes would need assistance finding housing to meet their preferences. In these cases the case manager would assist to identify apartments, or other housing options for the individual, which may include applying for subsidized housing. The case manager would arrange for visits to potential living arrangements and help the participant to secure other assistance needed to move. The case manager might need to utilize additional *transition services* dollars to arrange for deposits on rent & utilities, & furnishings such as a bed & linens. In addition to using Medicare & Medicaid waiver funds the case manager will access available state and local funding in order to maximize the supports available to the demo participant.

Individuals who have a traumatic brain injury or are frail elders will have access to the additional services offered by the TBI or FE waiver. The existing services available are a result of stakeholder input and reflect the unique support needs of these populations. The transition planning and plan of care (POC) development process is individualized for all MFP participants. So, though a case study may be somewhat different between the various populations served by MFP, it is expected that every individual's situation will be responded to through a person centered planning process. The timeline for transition will be as individualized as the plans of care, with each participant having access to up to 6 months of planning services prior to transition to the community. Some individuals will likely need a full 6 months to work through the potential barriers to transition while others may be able to move within 6 weeks of their initial community bridge building meeting/referral to MFP.

Person Centered Case Study 2 - John

John, age 42, has resided in an ICF-MR for fifteen years. He has moderate mental retardation and meets a Medicaid level of care for ICF services and is Medicaid eligible. Prior to moving into the ICF he resided with his parents at home. John's mother Irene lives within a one hour drive from the ICF, but his father died several years ago. John does not verbalize, read or write. He communicates with vocalizations, head nods and gestures. One of the goals in the ICF is to have John use a communication device to identify symbols and pictures to aid in his ability to understand and be understood. He is ambulatory and is able to take care of most of his personal needs with supervision. He needs support for some challenging behaviors that occur when John becomes frustrated due to his communication challenges. He also has some chronic medical conditions that require ongoing monitoring and support.

Identification

The ICF/MR where John is living is considering voluntary closure as part of MFP. Therefore the facility has been informing the individuals that live there and their guardians about the possibility of transitioning into community based services. Also in the last month the CDDO has contacted John & his Mother to fulfill their statutory requirement to inform individuals of all their service options annually. John's mother became his legal guardian when he was initially admitted to the ICF. When a person has a legal guardian they are included in discussing and arranging services for transition. John's Mother visits every week and stays very involved in his life.

John's mother, though not happy with the fact that the ICF is considering closing, understands that there are multiple service options to consider. When John was placed in the ICF the family thought he would remain there permanently. His mother has been very confident and satisfied with the care he receives in the ICF and she is skeptical about the capacity of the community services system to meet his needs and provide for his safety. She has agreed to look at community options.

First Irene selected an agency to provide case management. She chose the services offered by the same agency where John lives- they also offer HCBS waiver services. A case manager scheduled an appointment with John, his mother and John's qualified mental retardation specialist (QMRP) in the ICF to begin discussions about the planning process. This is an opportunity to explain the HCBS waiver and the MFP Demo processes. The case manager has received state sponsored HCBS waiver training and has attended the training on the MFP Demo provided by the state. The case manager has five years of experience in case management in HCBS waiver programs.

Pre-transition Planning

John's mother requested that the case manager meet with her to discuss her fears and to discuss the options in great detail. The case manager spent nearly two hours with her describing local services options, health care services available in the community, MFP program, how the HCBS waivers work and other basic information about choice and participant rights. Irene has received incident and accident reports from time to time from the ICF. She wanted to know what kind of reports she might receive in the community. She was also interested in knowing how community provider staff is trained. The case manager described the HCBS Critical Incident reporting process and gave a number of examples of how direct service staff are initially trained and what periodic training they receive.

The case manager left her with written material about MFP services and supports, copies of informed consent for her to review and an offer to discuss any questions that arise. It was explained that it is a voluntary program and that if John is to become a participant, explicit written information will be provided informing her (as consenting guardian) about all aspects of transition planning. Irene visited John and told him about what she was considering. John's response was a big smile which told her

she needed to try MFP and returned the signed consent form. John does have communication challenges, but people who know him well state they are able to understand his desires via his non verbal communication.

The next step will be to decide on community service providers. Plans were made for John & his Mother to visit various residential service providers during the following 3 weeks. The visits took place as planned with John, his mother and the case manager. They visited two community service providers that offer 4 person HCBS group homes and apartment settings. John seemed comfortable with the process and smiled when he saw the cat that belonged to one of the individuals they visited who resides in an apartment.

Transition Planning

It should be noted that John's Mother wants to play a major role in planning for his new community living arrangement. She is still not 100% sure that he will be better off in the community, but she knows she has the ability to influence and shape his supports. [For other individuals, whose guardians live farther away or who are unable to be as involved as John's mom, the case manager will spend a significant amount of time on the phone and through mailings to the guardian with information, consent forms and other planning materials.)

The case manager continued to work with John & his Mother to explore options of community service providers (CSP). John and his mother had the opportunity to interview and meet these providers and make choices about what they would like him to do. Once a CSP was selected the case manager initiated a person centered planning process to identify John's support needs along with his hopes and dreams. Individualized person centered planning allows for development of a plan of care that meets John's behavioral and medical support needs. A plan of care was developed that included the support services John needs and was submitted to the state Medicaid agency for approval and funding. The services included the demo service *Transition service* which helped John pay for his deposits on rent & utilities, buy furnishings such as a bed & linens. In addition to using Medicaid waiver funds the case manager accessed available state and local funding in order to maximize the supports available to John. John was very excited to go shopping for the new things he needed in his home. Another demo service, therapeutic support, which includes staff training, will be offered to support John in his transition to the community.

John and his Mother chose a provider that offers support in apartment settings and also offers day services. Irene liked the idea of all the services coming from one agency, at least to start with. The case manager explained their right to change providers for all or part of his services in the future, including the option to change case management agencies.

Transition

The case manager helped John apply for subsidized housing so that eventually his rent might be subsidized, which will make his budget less tight. In the mean time an apartment was located that satisfied all the needs identified in John's person centered plan (ex: near a grocery store or public transportation). The rent is affordable for John to pay with another roommate. One of his friends from the ICF is also moving out and they decided to share an apartment. Irene has observed John choosing to be near this individual, where most of his other roommates he tries to avoid. Irene asked John's staff about the potential roommate and they stated that both men seek each other out and choose to spend lots of time together. John is one of the only people who this potential roommate will allow to be in close proximity without getting upset. One staff member commented that another way

their friendship is demonstrated is that when John is eating a snack he will often offer some to his friend, where if anyone else approaches him while he is eating he works to hold his food away from them.

The case manager helped Irene to identify the options for physicians and dentist in the community. The speech therapy evaluation plan that had begun in the ICF will be completed in the community through a physician's order for a Medicaid covered evaluation. The local pharmacy will provide John's medication. John and his staff will walk to the pharmacy to pick up the monthly Medicare Part D covered prescription.

Nearly six months after the process began, John moved to his new apartment. The necessary supports were all in place and John did very well with the transition. He has staff 24 hours a day and they assist him in going out in the community. John receives the MFP demonstration service *therapeutic support*. This service helped his staff learn how to support his behavioral & medical issues and allowed for individualized staff support for John's support needs. In addition the residential service provider has nursing staff who provide 24 hour on call support for his staff should medical issues arise. They also provide regular wellness checks and check with his staff to make sure any medical issues are responded to. John now goes to the grocery store and the bank every week and gets very excited to get his cash. His day service provider offers transportation for John's activities though he & his staff choose to walk to the nearby store when the weather is good. His staff states that they have taken to walking to the store often because John seems to be more enthused about expressing his preferences for dinner at the store than at home. His communication device moved with him from the ICF and he regularly pushes the picture of the cat, indicating his desire to get a cat. John is working on saving up the money to get a cat and pay for the veterinarian bills. His roommate, who is verbal, is equally excited to get a cat. His Mother visits often and has been amazed at how John is doing. There have been some challenges but it seems that John has fewer behaviors now that there are less people around and he has staff who are better able to understand him.

Following his "discharge" the ICF permanently closed the institutional bed. Funding that was once used for his ICF care will follow him to the community on a long term basis. At the end of the year in the MFP Demo, John's services were automatically switched to waiver funding. If the case manager had not informed John's mother he was no longer in the MFP Demo, she would not have been aware based on any changes in the services and support. John continued to receive the services he needed and the case manager continued regular contacts with John, his guardian (mother) and the community service provider to see how things were going and to address any additional needs. It is hoped that John will become more participatory in making choices about where he goes and what he does.

2. Benchmarks

Provide a list of proposed annual benchmarks that establish empirical measures To assess the State's progress in transitioning individuals to the community and Rebalancing its long-term care system. The first two benchmarks were Specifically required under the MFP Demonstration.

Required Benchmark One – Persons Transitioned

The projected number of eligible individuals in each target group of eligible individuals to be assisted in transitioning from an inpatient facility to a qualified residence during each fiscal year of the demonstration.

****See Budget Chart, Appendix B***

Required Benchmark Two – Qualified Expenditures for HCBS

Qualified expenditures for HCBS during each year of the demonstration program.

****See Budget Chart, Appendix B***

Kansas, through utilization of the MFP demonstration project, will implement the following benchmarks. Two of the benchmarks are required by CMS and the additional three that have been developed with stakeholder input. These proposed benchmarks represent the goals identified during pre-implementation planning.

1. Reduction in the Number of Private- Licensed ICFs/MR Facilities and Certified Beds

Kansas currently has 262 individuals living in licensed Intermediate Care Facilities for the Mentally Retarded (ICF/MRs). SRS has targeted all private (ICF/MR) beds for voluntary closure. All current operators will be recruited to voluntarily close their facilities in accordance with current voluntary policies. SRS, in conjunction with KDOA, will work with these providers to close beds behind individuals who enter the MFP demonstration project. Incentive dollars will be offered to providers who agree to voluntarily close all currently occupied ICF/MR beds and cease providing ICF/MR licensed services at that facility and that do not request to open new beds in Kansas.

- Kansas will utilize demonstration enhanced matching funds to ensure access to slots on the MR/DD waiver. In some cases, enhanced dollars will be used to offset additional costs for community living for individuals with extraordinary support needs. While enrolled in the demonstration, these individuals will have access to supplemental service entitled “therapeutic support”. Kansas/SRS is committed to maintaining appropriate supports beyond the demonstration so that these individuals can continue to receive community based services upon exiting the demonstration project.
- Current ICF/MR providers who intend to become licensed HCBS providers will need specialized training for their staff. SRS will arrange training for staff who previously worked in ICF/MR facilities. This training will include the philosophical differences between institutional and home and community services. The training will also address person centered planning, self direction, consumer rights & responsibilities as well as independence and productivity in

natural community settings. The desired goal of the training is to ensure that staff members understand that every person has the opportunity to live as independently as possible.

Successful achievement of this benchmark will demonstrate:

- Overall reduction of the number of occupied ICF/MR beds by at least 80%.
 - Reduction of the number of private ICF/MR beds by 40 % at the end of calendar year 2008 with an estimated net remaining balance of 152 occupied beds
 - Reduction of the number of private ICF/MR beds by an additional 33 % (of the total occupied beds as of 1/1/2009) at the end of calendar year 2009, resulting in an estimated net remaining balance of 102 occupied beds
 - Reduction of the number of private ICF/MR beds by an additional 45% (of the total occupied beds as of 1/1/2010) at the end of calendar year 2010 resulting in an estimated net remaining balance of 56 occupied beds

2. Reduction in the Number of Individuals Requesting the Services of, or Residing in, State Operated ICF/MR settings State Mental Retardation Hospitals (SMRH)

SRS has targeted 95 individuals who currently reside in State Mental Retardation Hospitals to return to their home communities.

The specific targeted individuals include:

- Individuals that have demonstrated the lack of ability to be served successfully in their home communities due to potential sexual offender tendencies.
- Individuals that have demonstrated the lack of ability to be served successfully in their home communities due to aggressive physical behaviors.
- Individuals that have demonstrated the lack of ability to be served successfully in their home communities due to social or anti social tendencies.
- Individuals, that although they qualify for ICF/MR settings, could be successfully served in their home communities if the individuals' parents, guardians, and/or support networks were satisfied that the HCBS community service providers would have the continuing ability to successfully serve their sons, daughters, siblings, or wards.

Kansas will utilize enhanced community service dollars:

- To off-set additional costs for community living for individuals with extraordinary support needs. While enrolled in the demonstration, these individuals will have access to demonstration services entitled “therapeutic support”. This service will include behavioral support consultation, which will be utilized to provide specialized training of staff persons to support an individual’s unique behavioral issues. Kansas/SRS is committed to maintaining appropriate supports beyond the demonstration so that these individuals can continue to receive home and community services upon exiting the demonstration project.
- To provide or to acquire training and/or any qualification or certification necessary to best work with individuals with high behavioral, social, or offender-related needs or tendencies.
- To develop support for home and community services and supports targeted toward difficult to serve individuals. Support needs to be developed due to failure of such programs in the past.

- To establish an emergency relief / support network that will have the ability to immediately step into highly charged emergency settings to support and stabilize individuals experiencing difficulty.

The successful achievement of this benchmark will be demonstrated through the following outcomes:

- The 5 year average admission requests to the 2 SMRH settings is: 23 admission requests annually
 - Admission requests will be reduced by 2.5% resulting in no more than 22 admission requests 2008
 - Admission requests will be reduced by 2.5% resulting in no more than 21 admission requests 2009
 - Admission requests will be reduced by 2.5% resulting in no more than 20 admission requests 2010
 - Admission requests will be reduced by 2.5% resulting in no more than 19 admission requests 2011
- Overall reduction of 17% of all SMRH referrals

3. Rebalancing Long Term Care Institutional Care Cost in favor of Home and Community Based Services

The state of Kansas will achieve rebalancing through a 8 percentage point shift of HCBS spending over institutional costs by the end of the project. The target populations for the demonstration are cross age and cross-disability, including: elderly, physically disabled, persons with traumatic brain injury and individuals in ICF/MR settings, both private and public, and persons residing in State Mental Retardation Hospitals. The Kansas MFP demonstration project projects a reduction in LTC expenditures of over 20 million dollars.

The specific targeted numbers of individuals included and dollar expenditure estimates: Included in Appendix B

The successful achievement of this benchmark will be demonstrated through the following outcomes:

- 2008 47% Institutional 53% HCBS
- 2009 44% Institutional 57% HCBS
- 2010 42% Institutional 58% HCBS
- 2011 41% Institutional 59% HCBS

Overall rebalancing will result in an anticipated 39% Institutional to 61% HCBS which demonstrates an 8% reduction in Institutional expenditures.

Section I, Part B – Demonstration Implementation Policies and Procedures

Participant Recruitment and Enrollment

a. Participant Selection Mechanism

Include the criteria and processes utilized to identify individuals for transitioning. Describe the process that will be implemented to identify eligible individuals for transition from an inpatient facility to a qualified residence during each fiscal year of the demonstration. Please include a discussion of: the information/data that will be utilized (i.e., use of MDS or other institutional data); how access to facilities and residents will be accomplished; and the information that will be provided to individuals to explain the transition process and their options as well as the state process for dissemination of such information.

Identifying Individuals for Transition

Nursing Facilities.

Identification of potential MFP candidates within nursing facilities can occur one of three ways:

1. Referral for Money Follows the Person (via self, family, facility, ombudsman staff/volunteer)
2. Outreach/marketing of community based services & Money Follows the Person
3. Focused screening of individuals who expressed an interest to return to the community on the MDS, section Q1-A

Kansas will be obtaining a Data Use Agreement (DUA) for the Minimum Data Set (MDS) authorizing the sharing of information between the Department on Aging and transition team members, and the Kansas Long Term Care Ombudsman. Kansas Department on Aging legal department is currently working on updating the data use agreement with Meyers & Stauffer. Meyers & Stauffer is the data contractor with Department on Aging, who is responsible for tracking of MDS data within the state of Kansas. This data is the basis for identification of prospective participants, outreach to nursing facility residents and activation of a local transition team meeting. (See services chart: Community Bridge Building) Individuals identified via MDS data as interested in returning to the community (and guardians) on section Q 1-A will be notified via letter of the opportunity to meet with a transition team to explore community living and service options. Meyers & Stauffer will provide this data quarterly to the Department on Aging.

Of the 19,000 Nursing Home residents in Kansas, approximately 3500 have answered yes to Question Q 1-A. (indicating a desire to return to the community) Meyer's & Stauffer will further filter these names based on 6 month length of stay and Medicaid eligibility. We anticipate less than 2000 names of potential candidates that will receive a letter. This data will be sorted by county of residence (NF) and the notification will be staggered with a limited number to be contacted each quarter. The individuals to be contacted in each quarter will receive a letter and the team will offer dates to meet with individuals within 30 days of receiving the letter. The letter will explain why the individual is being contacted, provide information on how to decline a team meeting and how to contact the state Ombudsman's office for more information. The Ombudsman representative will follow up, via an in person visit, with the MFP candidate to ensure receipt of the letter and understanding. The Ombudsman representative will also confirm with individual their desire for a team meeting and any additional persons they would like to have attend the meeting. Should the resident want to decline the meeting this request should be made within 2 weeks of receiving the letter. Unless the team meeting is declined each identified individual will meet with the team to discuss potential community living options and Money Follows the Person. *See flowchart Appendix I

The transition team will consist of:

1. The Customer
2. NF social worker or transition staff
3. Area Agency on Aging (AAA) representative
4. Independent Living Center (ILC) representative
5. Customer's representative (when they have a legally appointed representative or when requested)
6. Peer Support as needed/requested

It is vital that all team members are present at each meeting as each member brings a different set of expertise that can assist the individual explore the possibility of moving back into the community. In addition, an ancillary benefit of the community bridge building team service will be the development of relationships between service systems that have previously been "siloes". The shared accountability of this team process allows for team members to observe one another's interactions with the customer and will help to alleviate concerns about differing approaches to informing the customer of their options. The team members will participate in a state sponsored training designed to maximize the effectiveness of the teams. The development of these local relationships will reinforce that everyone has the same goal, which is to ensure that the resident gets accurate, unbiased information about their service options and ultimately receives quality services of their choosing.

After receipt of information about community living options the individual can make an informed choice of either continuing to explore possible transition planning with a transition coordinator or saying no, and the process will stop.

Training of Transition Team Members.

All community based staff who wish to participate in local teams will successfully complete a MFP training provided by SRS & KDOA. This training is described in the marketing & outreach section.

A supplemental service has been developed as part of the demonstration project titled *Community Bridge Building*. (**See Services chart, Appendix C**). This service is designed to support the participation of a network of community based service providers in local transition team meetings. Training will be provided across the state in each region and will be a requirement for participation in transition planning with MFP participants.

Identification of residents is also built into the CARE Program, the state's NF pre-admission screening and follow-up program. The pre-admission screening contains a question that asks if the person wishes to leave the nursing facility in 90 days, and then case managers conduct a 30-day and 90-day follow-up with the resident. While these individuals will not meet the residency requirement for our federal MFP program, the state will work with these individuals to pursue community living options.

ICFs/MR Public & Private.

Identification of potential MFP candidates within ICF's/MR will occur via referrals, marketing and targeting of beds for voluntary closure.

Individuals receiving ICF/MR services have been determined eligible for HCBS MR/DD community services. The individual and/or the individual's guardian have made the choice for institutional services. All persons receiving institutional services and their families are by statute provided information regarding community services through the local Community Developmental Disability Organization (CDDO) on an annual basis.

Public- State Mental Retardation Hospitals (SMRH).

All individuals receiving services in either of the two State Mental Retardation Hospitals (SMRH) will be provided the opportunity and benefits of receiving services in a community setting. Specifically, the state of Kansas will target approximately 90 individuals who are receiving now or at some time during the next five years will reside in the SMRH with a treatment plan that is specifically focused on offender behaviors. These specific behaviors have in many cases been proven to be beyond the ability of community providers. The incentives available through the MFP demonstration project would provide for the specialized technology and staff training that would ensure that each of the individuals will be able to transition into the community effectively.

Closure of Private ICFs/MR.

As part of the MFP Demonstration, Kansas plans to target privately operated ICFs/MR who agree to voluntary closure. In addition to the above information provided to individuals residing in an ICF/MR, a facility that has chosen to voluntarily close will be required to submit a closure plan for approval to SRS/Division of Disability & Behavioral Health Services/Community Supports and Services. Closure plans must detail how individuals who reside in the facility will be informed of intent to close, be informed of their choice of community service options, be provided with a choice of TCM, and be in control of timelines for moving.

Unlike some states we have very few remaining ICF/MR facilities. While we are hopeful that nearly all ICF/MR providers will choose to participate in voluntary closure via MFP we are specifically targeting two facilities for closure. The first identified target for ICF/MR closure was our largest remaining ICF/MR, which currently has 56 licensed beds. It is located in Southeast Kansas. Our second target for closure is our second largest ICF/MR which has three facilities with 15 beds each for a total of 45 licensed beds. They are located in Northwest Kansas.

Access to Facilities

Through stakeholder involvement in development of our participant identification process, concerns about access to nursing facilities have been addressed. A partnership now exists between our two associations of nursing home providers (KAHSA & KHCA) and the network of community providers including independent living centers & area agencies on aging. All partners have agreed to the aforementioned process to assure that facility staff and the state ombudsman program will be notified

of the individuals who will be contacted for possible participation in the MFP demonstration. Our transition teams are committed to fostering a supportive and positive relationship when approaching potential MFP enrollees. If access issues emerge we will work with our partners to resolve these issues at the state public policy and regulatory level. In addition our long term care ombudsman program will continue to respond to any complaints regarding resident rights to information about service options or access to facilities when a resident has requested information on community living options.

Dissemination of Information

Staff from SRS & KDOA will market the MFP Demonstration by providing educational seminars and information about the MFP demonstration to organizations across the state. (Please reference the *Outreach/Marketing/Education* section of the *Operational Protocol* for further detail)

b. Qualified Institutional Settings

The qualified institutional settings that individuals will be transitioning from, including geographical considerations and targeting, the names of the facilities for the first year, and an explanation of how the facilities being targeted meet the statutory requirements of an eligible institution.

Individuals will be transitioning from Medicaid certified nursing facilities or intermediate care facilities for persons with mental retardation as defined in Section 6071(b) (3) of the DRA. This MFP Demonstration project will be available statewide for individuals residing in qualified institutional settings.

c. Minimum Residency Period

The minimum residency period in an institutional setting and who is responsible for assuring that the requirement has been met.

All MFP Demonstration participants will meet the minimum residency requirement of at least six months.

Nursing Facilities

KDOA and SRS will identify a list of qualified individuals residing in qualified nursing facilities based on date of admission from the MDS data who also responded affirmatively on section Q. For individuals referred through other means than the targeted MDS identification, verification will be requested by the transition coordinator from the SRS eligibility worker. Written verification that an individual has met 6 month residency requirement will be provided to the transition coordinator from the SRS eligibility worker and copy of documentation will be part of the individual's service file.

ICFsMR & SMRH

Transition coordinators will review the individual records of people interested in MFP to provide initial confirmation that the residency requirement has been met for individuals residing in ICFs/MR. Verification that individual has met 6 month residency requirement will be requested by transition coordinator from the SRS eligibility worker and copy of documentation will be part of the individual's service file.

d. Participant Eligibility for MFP Demonstration.

The process (who and when) for assuring that the MFP participant has been eligible for Medicaid a month prior to transition from the institution to the community.

SRS has the responsibility for determining and certifying financial eligibility for Medicaid participants. Medicaid enrollment or eligibility will be initially identified by NF or ICFs/MR staff for potential MFP participants. Written verification of Medicaid status will be requested by the transition coordinator from the SRS Medicaid eligibility workers.

e. Re-Enrollment into the Demonstration

The State's policy regarding re-enrollment into the demonstration. That is, if a participant completes 12 months of demonstration services and is readmitted to an institution including a hospital, is that participant a candidate for another 12 months of demonstration services? If so, describe the provisions that will be taken to identify and address any existing conditions that lead to reinstitutionalization in order to assure a sustainable transition.

For those individuals readmitted to an institution before completing their 365 days of demonstration participation, their 365-day entitlement will resume upon re-entering the community setting. Individuals may re-enroll into the MFP Demonstration at any time if they are Medicaid eligible and have completed a thorough review of the original transition to mitigate any problems for a second attempt at transition. Individuals who re-enroll into the MFP Demonstration will not receive a new 365 days of eligibility, instead the length of eligibility will be based on the number of days not utilized during their previous participation. As an example, if an individual is in MFP for 200 days and is then disenrolled from the program they have 165 days of remaining MFP eligibility. Upon re-enrollment the individual will be informed that they have 165 days of project eligibility prior to transitioning to traditional HCBS waiver services.

f. Information to Make Informed Choices

The State's procedures and processes to ensure that participants will have the requisite information to make choices about their care.

Participants will have requisite information to make choices about their care. The ability of an individual to receive adequate information and make informed choices about living arrangements and the type of services available is central to the Money Follows the Person demonstration program. Each of the Medicaid 1915(c) waivers used to transition individuals from nursing facilities, ICFs/MR, or state hospitals (SMRH) back into the community requires that the state not only assure, but develop discovery mechanisms to substantiate that participants are afforded choice: 1) between 1915(c) waiver services and institutional care, and 2) among 1915(c) waiver services and long-term service and support provider, and 3) option to choose between self-directed or agency directed services.

Additional processes for individuals residing in ICFs/MR & SMRH:

Individuals that are residing in private ICFs and their guardians will be provided specific information and support regarding the opportunities of community services by the CDDO from the area in which that individual resided.

The MFP project director will work in coordination with the CDDO representing the home communities of all residents residing in the two SMRH's and will annually present information regarding the

benefits and availability of services in the person's home community to assist the individual & family to make an informed choice.

2. Informed Consent and Guardianship

Provide a narrative describing the procedures used to obtain informed consent from participants to enroll in the demonstration. Specifically include the State's criteria for who can provide informed consent and what the requirements are to "represent" an individual in this matter. In addition, the informed consent procedures must ensure all demonstration participants are aware of all aspects of the transition process, have full knowledge of the services and supports that will be provided both during the demonstration year and after the demonstration year, and are informed of their rights and responsibilities as a participant of the demonstration. Include copies of all informed consent forms and informational materials.

a. Procedures for Providing Informed Consent

i. Criteria and requirements to provide informed consent and represent an individual.

Kansas assures that all individuals participating in the MFP Demonstration (& Guardian, when appropriate), be informed of all their rights and options for long-term services and supports and that participation is voluntary. This includes acceptance of services and the consent to participate in the evaluation component of the grant. The *Informed Consent Form (Appendix D)* will be signed only by the individual being transitioned or those who have legal authorization to act in the individual's behalf. Transition coordinators will obtain the appropriate signatures on the *Informed Consent form (Appendix D)* which indicates that they have been informed and are voluntarily choosing to participate in the MFP Demonstration without coercion.

If a guardian has been appointed for a prospective MFP Demonstration participant, the transition coordinator will ensure the guardian is included in discussions about service options. The guardian will be included in all aspects of recruitment & communication about MFP, including the initial letter that will be sent to nursing home residents who expressed an interest in returning to the community.(see Section B Participant Recruitment & Enrollment for further details) The transition coordinator will explain the choices of the prospective MFP participant, key features of the MFP Demonstration program, and various long-term services and support options that are available to the individual. If a guardian refuses participation in MFP, despite interest by the resident, then a referral will be made to the Ombudsman program to work with the individual & their guardian to explore options. The MFP program cannot override the legal guardian but we can work to educate the guardian about community living options and make referrals to advocacy agencies that will work to support the individual in pursuing all their rights under the law.

Kansas guardianship law states that a guardian cannot gain or profit from a ward, as it is seen as a conflict of interest. Therefore policies are in place within our HCBS waivers that prevent the guardian from arranging for services for which they will profit. Nursing home licensure also includes similar restrictions which state per KSA 28-39-163c “*Anyone employed by or having a financial interest in the facility, unless the person is related by marriage or blood within the second degree to the resident, shall not accept a power of attorney, a durable power of attorney for health care decisions, guardianship, or conservatorship.*”

ii. Awareness of Transition Process/Knowledge of the services and supports

Section 1, Part B1 of the *Operational Protocol* identifies the transition process and information provided to the individual (or guardian) for both nursing facility and ICFs/MR. Program administrators, advocacy organizations and community service programs will utilize a process which ensures participants are provided information in a format that is clear and understandable. The information provided will address both institutional and community options, including services available to the individual during and after the demonstration, as well as all aspects of the transition process. The state will train transition coordinators and targeted case managers who are responsible for assuring individuals are making informed choices and respecting individual rights. In addition, participants will be made aware of the critical incident reporting process, which is included in each of the approved 1915 (c) waivers that will be utilized for MFP.

iii. Information about Rights and Responsibilities

Informed consent under this MFP Demonstration will include two components: 1) the acceptance of services and; 2) the consent to participate in the evaluation component of the project. The consent for waiver services will follow current 1915(c) waiver practices (as dictated by CMS) and will be obtained prior to the delivery of home and community-based services. Additional supports necessary to carry out the service plan will be fully explained to the prospective MFP Demonstration participant or representative, particularly with regard to self-directed services and supports.

The *Informed Consent* form will include the provision that participation in the MFP Demonstration is voluntary and protects project-related information that identifies individuals. The document states that the information is confidential and may not be disclosed directly or indirectly, except for purposes directly related with the conduct of the project.

Finally, the *Informed Consent* form advises the individual that they can withdraw from the project at anytime, the MFP Demonstration period is for one year, the special demonstration services are available for one year, and that their existing Medicaid 1915(c) services will continue after the MFP Demonstration period as long as they continue to meet the eligibility requirements for the program.

b. Guardian Relationships

Provide the policy and corollary documentation to demonstrate that the MFP demonstration participants’ guardians have a known relationship and do interact with the participants on an ongoing basis; and have recent knowledge of the participants’ welfare if the guardians are making decisions on behalf of these participants. The policy should specify the level of interaction that is required by the State. In addition, the State must set the requirements for, and document the

number of visits the guardian has had with the participant within the last six months. This information must be available to CMS upon request.

The demonstration participant or the participant's legal guardian may provide informed consent. If an individual's legal guardian provides the informed consent, the state will verify that the guardian indeed has legal jurisdiction over this choice. Kansas guardianship law does not require documentation of a relationship, including how many visits, to be tracked. The MFP project will comply with existing state guardianship laws, which do not require documentation of the relationship/contact between the guardian and their ward, so therefore specific qualifications regarding guardian relationships were not established by our MFP work group. However, every effort will be made to work with guardians to establish working relationships and to educate the guardian about community living options. Additionally, referrals will be made to the Ombudsman's program or other advocacy agencies when there is a lack of agreement between the individual's desire and the guardian's decision. The ombudsman role is to represent the individual (nursing home resident) and to work through these disagreements with the customer's wishes in mind. Referrals can be made to advocacy agencies who will explore additional options with the individual and ensure that the individual is aware of their legal rights and options.

3. Outreach/Marketing/Education

Submit the State's outreach, marketing, education, and staff training strategy. NOTE: All marketing materials are draft until the Operational Protocol is approved by CMS. Please provide:

a. Information to be communicated to enrollees, providers, and State staff

During the months of April through July, 2008, the Project Director from SRS and her counterpart at KDOA will hold a series of meetings across the state to describe the Money Follows the Person demonstration and the particular objectives it plans to meet. Eligibility for the project and the opportunities afforded by the demonstration project will be discussed. An informational PowerPoint presentation will also be developed to market the MFP demonstration project.

Within the state system, ongoing communication and education has been occurring. The MFP Project Director and KDOA staff has met with program managers for each of the Home and Community Based Services waivers, the, Division of Economic Assistance with Social and Rehabilitation Services, Kansas Health Policy Authority and EDS (state fiscal agent) for system design.

In the community, outreach has begun and will continue with seniors, individuals with disabilities, service providers, advocacy organizations and other stakeholders. Key stakeholders include, but are not limited to: Kansas' two professional associations for nursing facilities and residential services (KAHSA & KHCA); Independent Living Centers and their associations (KACIL, SILCK, & TILRC), the Area Agencies on Aging and their association (K-4A); a representative of the network of providers for traumatic brain injury services (Community Works) and the state long term care Ombudsman office, the two professional associations for service providers in our DD system (Interhab & the Alliance), consumer advocacy groups (SACK, AARP, KABC, ADAPT, Silver haired legislators), and the Kansas Housing Resources Corporation. Examples of outreach that has already occurred include presentations at: conferences for statewide nursing home associations, board meetings for provider associations, & statewide steering committee and work group meetings

The Kansas Long Term Care Ombudsman staff has ongoing contact with nursing facilities statewide and will continue to educate nursing facility residents about their rights & the array of service options. They continually visit all nursing facilities and have typically cycled through every facility within a 6 week period. Their role is to work with residents and assist them in resolving any concerns they may have. Their presence in the nursing facilities will allow them to play a role in identifying nursing facility residents who might be interested in MFP services and to make appropriate referrals. The ombudsman's staff will follow up with persons who are interested in MFP via their existing role of providing residents information about their service options. However, they are not expected to be an expert on MFP services, they will have a working knowledge of the program in order to help residents understand their options but formal transition planning will occur with Community Bridge Building

teams and transition coordinators, In addition Money Follows the Person staff will contribute to the training curriculum for ombudsmen staff to ensure they have a working knowledge of our MFP demonstration and are prepared to answer questions that residents may have. The Ombudsman program staff/volunteers are supervised by Gilbert Cruz, Kansas State Long-term Care Ombudsman

Upon approval of the *Operational Protocol* training will be developed by SRS and KDOA for Transition Coordinators and Case Management across the identified regions of Kansas. Training will continue to be offered as the need to train additional staff arises. Kansas has 105 counties and TCS/TCM is available in each county through existing service providers. TCS and TCM services will be available throughout the entire state. Kansas assures adequate number of TCM's and TCS's to meet the needs of individuals without establishing specific ratios. Monitoring of these activities is tied to individualized outcomes rather than numbers of persons served. After completing the required MFP training we will have a network of specialists who are specifically trained to help individuals plan for transition back to the community via our MFP project. There are 11 previously identified service areas designated for AAA's, which will be used to determine the regions for community bridge building teams. Each region will have MFP trained team members who will act as the conduit for information about the program and help the MFP customer access and utilize the benefits afforded to them. Training of these staff will occur in May & June of 2008 in order to prepare them to begin assisting program enrollees with preparing for transition. SRS and KDOA project directors will continue to provide training and engage in marketing and outreach through-out the demonstration project.

Marketing tools are being developed and will take a multi-faceted approach. Our marketing task team is working on developing these materials to ensure stakeholder involvement in the project. Kansas will develop short, easy to read informational flyers with contact information for a variety of settings, including within the institutional settings and community locations which will reach a large audience. Examples of locations for informational flyers includes: medical clinics, Doctor's offices, Hospital settings, community centers, meal sites, rehabilitation centers, libraries, Area Agencies on Aging offices, & Centers for Independent Living offices.

Kansas has also created a transition handbook, which will walk someone through the process step by step through the MFP process. This book will also address topics on housing; transportation; funding and benefit programs; meal site information; self direction; supplies and equipment; and developing support systems. Kansas will leverage existing mails and communication loops to aid in the dissemination of information. We will also have information on the SRS and KDOA website.

See Draft Transition Handbook, **Appendix E**.

In addition to existing processes that are utilized, Kansas will strengthen our systems for informing individuals and families about community based services. This system will be technology based and rely upon current community partners. Kansas has a strong, well defined and highly agile service delivery system which relies on a partnership with the Kansas Department on Aging and the Kansas Department of Social and Rehabilitation Services. The organizations providing the community face to the Kansas eligibility determination, assessment, referral and resource development are: Community Developmental Disability Organizations (CDDOs) which act as gatekeepers for the Developmental Disability (MR/DD) system, Independent Living Centers and home health agencies which act as gatekeepers for the Physical Disability (PD) and Traumatic Brain Injury (TBI) systems, and Area Agencies on Aging (AAAs) which serve as the access point for services for seniors.

In addition, the Kansas Department on Aging (KDOA) is implementing an Aging and Disability Resource Center (ADRC) grant, with added resources from the Department of Social and Rehabilitation Services' (SRS) Real Choice Systems Transformation grant. The Aging and Disability Resource Center (ADRC) project is a nationwide initiative sponsored by the US Administration on Aging and the Centers for Medicare and Medicaid Services. Kansas Department on Aging (KDOA) was awarded the grant for this project in 2005. KDOA is working with a coalition of state agencies, service providers, advocacy organizations and consumers to develop this project. In Kansas, the project is using a consumer-friendly "no wrong door" approach to streamline access to program information, application processes, and eligibility determinations for all aging and disability services. ADRCs will provide Access, Assistance, Awareness and Information to all Kansans seeking help. The Kansas ADRC project is working with pilot communities to foster collaborative relationships between agencies that serve different populations. ADRC will improve access to information about services by developing a web-based resource manual, increasing public awareness of ADRC, developing a web-based referral tool and providing cross training to staff of collaborating agencies. ADRC will also develop a system to help streamline eligibility determinations for Medicaid and other programs.

Another resource is a 211 telephone number which also connects people with important community resources. This statewide service is available between 7:00 am and 7:00 pm, Monday through Friday. United Way 211 helps callers locate resources such as food banks, clothing, utility assistance, shelter, transportation, individual and family support services, credit counseling, and employment services. Included in this array of resources is information on community services for individuals with disabilities. One call gives Kansans access to thousands of resources in Kansas communities. All calls are confidential and free.

b. Types of Media to be used:

The type of Media to be used will include written informational materials, electronic media and interactive training curriculum. In addition we will leverage existing relationships with various stakeholders groups to distribute educational information to consumers via their existing information networks.

- Brochures/flyers will consist of easy to read information that will tell the participants and interested parties about MFP and the services that would be available to them.
- An informational poster about MFP for placement in current qualified institutional settings.
- Electronic Media will include:
 - Modifications to SRS & KDOA website beginning with the addition of the CMS approved brochure.
 - Testimonials from interested MFP clients, families, and providers.
 - Public service announcements.
 - We are currently researching the feasibility of creating videos and web based media to communicate project information and success stories.
- Kansas will also be working with the Aging and Disability Resource Center (ADRC) and the United Way 211 telephone number in our state, which links to resources throughout Kansas. These agencies provide information, outreach, resource development, and education to participants, providers, and the general public.

c. Outreach/Education

As soon as the MFP Operational Protocols are approved by CMS, training and educational forums and other types of outreach will be scheduled in Kansas. Educational forums will be scheduled and offered statewide to SRS Staff, KDOA staff, LTC Ombudsman staff, AAA Staff, Centers for Independent Living staff and CDDO staff, service provider network staff, hospital discharge planners, consumer and stakeholder networks. This is a preliminary list that will continue to be expanded as we identify additional entities for outreach & education about MFP.

Who will be educated through training and educational materials:

- Provide informational forums through NF contacts to staff including **NF social workers**.
- Connect with **hospital discharge planners** to provide MFP information.
- Inform **Nursing Home Associations** at SRS/ KDOA meetings/Department forums.
- Inform **physicians, nurses and other hospital medical staff** informed via brochures, mailings.
- Provide MFP training to **Ombudsman staff and volunteers** statewide
- Educate **ADRC Agencies**.
- Provide training and education to our **partners (Community Developmental Disability Organizations, Home health agencies, Community service providers, Centers for Independent Living, and Area Agencies on Aging)**.
- Educate the **Kansas Housing Resources Corporation (KHRC) and regional housing authorities** about MFP and the benefit of adding supportive services.
- Educate **Adult Protective Services**.
- Educate **Transportation Providers**.
- Educate **MDS Assessors** on MFP.
- Educate **Kansas Guardianship Program** on MFP.

Specific geographical areas to be targeted

All MFP Demonstration activities will be statewide therefore our marketing and outreach activities are not limited to any geographical area. Marketing and outreach will occur statewide. This preliminary list of locations for distribution will continue to be expanded as we identify gaps or additional opportunities for dissemination.

d. Locations where such information will be disseminated

- NF contacts to staff including NF social workers
- Hospital discharge planners to provide MFP information
- Nursing Home Associations at SRS/ KDOA meetings/Department forums
- Doctor's offices inform physicians, nurses and other hospital medical staff informed via brochures, mailings
- Ombudsman staff and volunteers statewide
- ADRC Centers
- Community Developmental Disability Organizations, Centers for Independent Living, and Area Agencies on Aging
- Regional housing authorities and housing resources

- Adult Protective Services
- Transportation Providers
- MDS Assessors
- Guardianship Programs
- State websites
- Hosting educational workshops for providers on consumer eligibility and MFP
- Leveraging existing relationships with various stakeholder groups to distribute educational information to consumers

e. Staff training schedules, schedules for state forums or seminars to educate the public

Kansas has held and will continue to hold state forums to educate the general public regarding MFP and the opportunities it can provide to residents interested in moving back to the community. Information sessions will be held quarterly during the initial program implementation and semi-annually after that. This will provide an additional mechanism for continuous stakeholder feedback. These statewide forums will be held around the state and will have a toll free call in line that allows access from anywhere in Kansas. Staff training will be developed and provided within identified regions of Kansas. The MFP training will occur within April thru June 2008 in anticipation of the July 2008 start up. Additional meetings and trainings will be scheduled according to the request and needs of identified groups.

Two state wide information sessions/ forums have occurred to educate the public about the current status of the project and to solicit feedback. The first occurred in the summer of 2007 to announce the receipt of the grant and plans to hire a project director. The next one was held January 31st, 2008, to inform the public of the current status of planning for program implementation. At the next public forums we look forward to announcing the approval of our *Operational Protocol*.

f. Availability of bilingual materials/interpretation services and services

All of Kansas 1915(c) waiver programs offer bilingual materials/interpretation services for non-English speaking clients or individuals with communication limitations. Written materials in a person's primary language will be available; written material will also include the consumer rights and responsibilities. Any forms requiring a customer's signature will be translated. Communication access assistance will continue to be provided as needed via Kansas Communication Access System. Electronic formats for will also continue to be available. Audio versions of MFP related documents will be available on the SRS/ MFP website for people with visual impairments. Staff may use the language line for additional language interpreter needs. In addition, individuals & providers can access the Kansas Relay Center for TTY service.

g. How individuals will be informed of cost sharing responsibilities

As part of the normal 1915(c) waiver enrollment process, transition Targeted Case Managers will inform individuals verbally and in writing of any cost sharing responsibilities. Cost sharing will be discussed at the time of the assessment and establishing eligibility. The participant is fully informed of any cost sharing responsibilities. Eligible individuals are also informed of cost sharing through their Medicaid award letter. Any changes to the cost sharing amount generates a letter of notification to the consumer from SRS in the form of a 3161 notice, and from the HCBS case manager in the form of a notice of action.

4. Stakeholder Involvement

Describe how the State will involve stakeholders in the Implementation Phase of this demonstration, and how these stakeholders will be involved throughout the life of the demonstration grant. Please include:

Chart that Reflects Stakeholders Relationship and How they Influence the Project.

a. Stakeholder Organizational Chart. (See Stakeholder Chart, p 41)

Once the application for the MFP Demonstration was approved by CMS, work began to form the Money Follows the Person Demonstration Steering Committee. The Department of Social and Rehabilitation Services, in collaboration with the Kansas Department on Aging and stakeholders, formed a Money Follows the Person Steering Committee. The Secretaries of SRS and Aging appointed members to the task force to assure that there is a consistent minimum 51% direct consumer / family / guardian representation. Additional members include: advocacy organizations across all disabilities; community service providers; provider organizations; and representatives of state agencies. The Steering Committee has been integral in the program planning during the pre-implementation period. The Steering Committee will monitor the progress of the demonstration project and make recommendations to the Secretaries of SRS and KDOA. The Secretaries of SRS and KDOA have committed to implement and to advocate for the implementation of the recommendations made by this body within the scope of their responsibility.

While previous state initiatives, such as the 2002 Real Choice Systems Change grant, the 2006 Real Choice Systems Transformation grant, the 2002 C-PASS grant, and the 2001 planning grant to develop and enhance the statewide Traumatic Brain Injury service-delivery system, have brought these groups together, the “Money Follows the Person” demonstration provides an additional opportunity for these groups to partner for the common goal of ensuring that all Kansans have the opportunity to be supported to successfully live in settings of their choice. A great deal of time has been dedicated to a process of promoting meaningful stakeholder participation in development of this Operational Protocol. We feel confident our OP represents a plan that is the result of meaningful participation by consumers, service providers, and advocacy organizations that are invested in successful implementation of Money Follows the Person and in rebalancing long term care services in Kansas

b and c. Consumer and Institutional Providers Involvement

Direct consumers of services, advocates, and both community and institutional providers will continue to play a critical role in the implementation and ongoing activities associated with this MFP Demonstration. These groups played a critical role in the development of the MFP application and this *Operational Protocol*.

As previously stated, a Money Follows the Person Demonstration Steering Committee has been established for this MFP Demonstration that includes consumers, a mix of rural and urban providers, institutional and community providers, and statewide advocacy groups. We will continue to recruit additional direct consumer members. Because of the geographical size of the State, conference call-in access is provided at all of its meetings. In addition, anyone who wishes to attend and participate in the Money Follows the Person Demonstration Steering Committee meetings is welcome to attend and contribute to the discussions.

The Operational protocol task team members' primary role has been to participate in the design of the *Operational Protocol*, and in the implementation of the MFP Demonstration.

The Money Follows the Person Demonstration Steering Committee and smaller task teams will monitor and provide direction for this MFP Demonstration through successful conclusion.

Institutional providers have representation on the Money Follows the Person Demonstration Steering Committee, and have been active participants in the development of both the MFP Demonstration and this *Operational Protocol*.

d. Consumers' and Institutional Providers' Roles and Responsibilities

The purpose of the Money Follows the Person Demonstration Steering Committee is to ensure participation by consumers and institutional providers in the design of the *Operational Protocol* and to monitor implementation of the MFP Demonstration throughout the five-year period. The committee will guide *Operational Protocol* development, provide feedback, and monitor MFP Demonstration implementation and progress, and review progress on achieving our benchmarks.

Additional activities of the Money Follows the Person Demonstration Steering Committee:

- Completed development, in partnership with the nursing facilities, of a protocol that will be followed to
 - ensure consumers in nursing facilities are aware of their options
 - ensure family members are aware of their options
- Completed development of a transitions process that will:
 - identify "who" will serve as transition counselors
 - determine training required
 - ensure all persons' rights to privacy are protected
 - ensure all "qualifiers" have been met prior to transitioning
 - ensure that the individual is eligible for an HCBS program to meet the person's needs in the community
 - ensure that, if the person is self-directing, qualified staff are available
 - ensure that Durable Medical Equipment (DME) is or will be on location the day the person leaves the institution
 - ensure that DME and technology that was purchased with dollars / benefits specific to that person are transferred with the person
 - ensures that a residence that meets the qualifications has been secured
- Continue development, in collaboration with SRS / KDOA, diversion strategies designed to keep persons out of institutional settings thereby preserving the individual's assets *and community living setting*.

e. Operational Activities with Consumers and Institutional Providers

Specific sections of the *Operational Protocol* have been assigned to various task teams, which are smaller sub-groups of the steering committee. Participation on task teams was not limited to only appointed members so that we could draw upon expertise from additional stakeholders who were committed to the intensive work of pre-implementation planning. Anyone interested in participating in the MFP Demonstration was invited to assist in the development of the *Operational Protocol*. The task teams are in various stages of their ongoing work to implement the demonstration. These task teams will continue their work in implementation of the demonstration.

The Money Follows the Person Demonstration Steering committee has, and will continue to, meet monthly. An additional steering committee meeting occurred in January for review of the *Operational Protocol* prior to submission to CMS. A public forum was hosted on January 31, 2008, to provide an update on planning activities and solicit feedback from stakeholders across the state. Conference call-in access was provided for these meetings.

Below are listings of the task teams that are critical to planning & implementation of our demonstration.

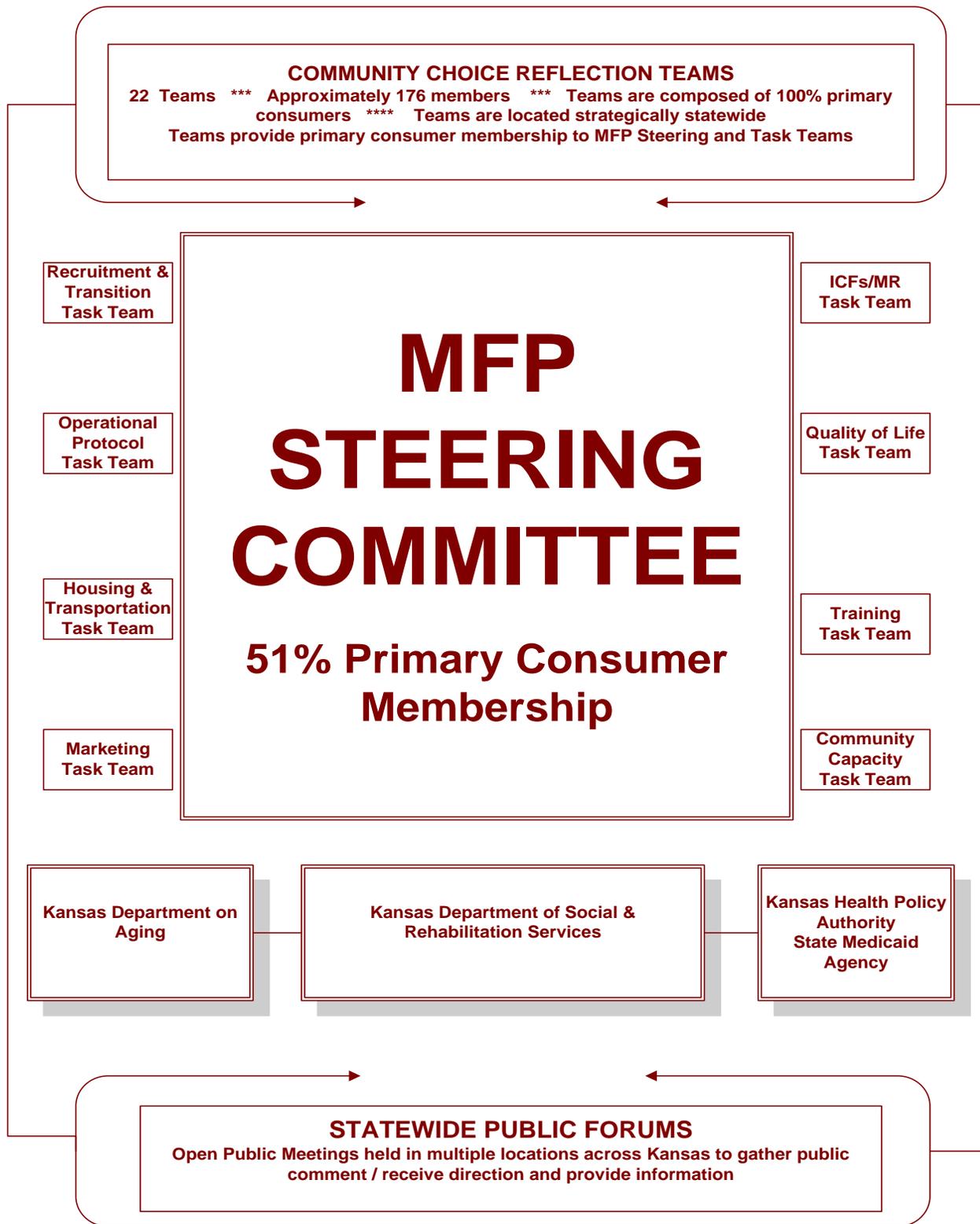
Money Follows the Person Demonstration Task Teams:

1. Operational Protocol – inform development of the OP, particularly all areas where we have the option to be creative and establish new processes associated with MFP. (most members will join the Participant Recruitment & Transition task team upon approval of our OP)
2. Participant Recruitment & Transition - continued review of how participant recruitment & transition process is working, including Community Bridge Building team process and use of MDS data
3. Training - inform development of training(s) curriculum for individuals who will be part of Community Bridge building teams, provide transition coordination or targeted case management to MFP participants
4. Marketing - coordinate marketing plan, including creation of & distribution of marketing materials
5. ICF's/MR - specific to individuals transitioning out of ICF/MR's and related benchmark activities. There are two subgroups of this task team: 1. Private ICF/MR/voluntary closure 2. State MR Hospitals- issues specific to serving individuals with high risk behaviors or who have not succeeded in community placement in the past
6. Quality of Life - specific to quality of life surveys that are required for all MFP participants, will review the data from the surveys conducted in Kansas, will also discuss MFP state project evaluation
7. Housing - to work on advocacy efforts related to housing issues & develop resource packet on how to work with your local housing authority regarding increased housing options for MFP participants
8. Transportation - to work on advocacy efforts related to transportation issues & develop a resource guide on model programs/funding options around the state
9. Community Capacity will work on multiple efforts tied to community capacity issues that MFP is attempting to respond to

For purposes of completing the *Operational Protocol* many of the task teams were combined due to both time constraints and the commitment of many stakeholders who wanted to participate in all aspects of the planning; this group was referred to as the *Operational Protocol Task Team*. Now that the *Operational Protocol* is completed the group will split out into their respective areas of focus regarding further planning, program implementation and monitoring.

Another avenue for getting feedback from direct consumers of service is via our Community Choice Reflection teams. These teams are coordinated by regional SRS Program Improvement Staff who have recruited direct service recipients from their area. The goal of each team is to provide feedback

about current service delivery and to review proposed changes and offer their opinion. These teams have been forming over the last few months and are in the process of developing a communication process as part of our System Transformation Grant.



5. Benefits and Services

a. Description of the Service Delivery System

Provide a description of the service delivery system(s) used for each population that the State will serve through the Money Follows the Person Rebalancing Demonstration. Include both the delivery mechanism (fee-for-service, managed care, self-directed, etc.) and the Medicaid mechanism through which qualified HCBS will be provided at the termination of the demonstration period (waiver, 1115 demonstration, Medicaid State Plan, etc.). For all HCBS demonstration services and supplemental demonstration services, there is no Medicaid mechanism understanding that the services terminate with the 365 day demonstration period; however, the State must detail the providers or network used to deliver services.

A separate demonstration 1915(c) waiver will not be created for the MFP Demonstration. After the 12-month demonstration period, individuals will continue in the same 1915(c) waiver program as long as they meet the eligibility requirements of the program. SRS operates three 1915(c) waivers that are part of this demonstration; Mental Retardation/Developmental Disabilities Waiver (MR/DD), Physical Disability Waiver (PD), and the Traumatic Brain Injury Waiver (TBI). The Kansas Department on Aging operates one 1915(c) waiver, the Frail Elderly Waiver (FE).

Kansas is recognized as a state with a strong self-directed service delivery model in place. Due to the leadership of strong stakeholder/advocacy groups, in 1989 Kansas passed a law guaranteeing that all individuals over the age of 16 who receive personal care services from the state have the right to self-direct these services. All four of the Medicaid waivers included in this demonstration allow program participants to self-direct their care. These programs permit participants to hire a worker of their choice and direct their own care or have a provider direct their care for them. The option to self-direct is chosen by 87% participants in the Physical Disabilities Waiver program, by approximately 80% participants in the Traumatic Brain Injury program, 33% participants in the MR/DD Waiver program, and 42% participants in the Frail Elderly Waiver program.

An in-depth analysis of the self-direction is contained in Part B, Section 7.

Kansas assures CMS that all Demonstration participants will be eligible under the Waiver cost limits approved by the State when transitioning from the Demonstration to the population at-large as long as they meet all the other eligibility criteria.

Provider manuals for all home and community based 1915(c) waivers can be accessed at the following website:

<https://www.kmap-state-ks.us/>

All aspects of the home and community based 1915(c) waiver programs are under continuous quality review. Accordingly, the websites have the most up to date program information.

b. Available Service Package

List the service package that will be available to each population served by the Demonstration program. Include only services that are provided through the demonstration (home and community-based long-term care services and supplemental services). Do not include acute care service or institutional services that will be paid for through the regular Medicaid program. Divide the service list(s) into Qualified Home and Community-Based Program Services, HCBS demonstration services, and supplemental demonstration services reflecting the categories of services that are listed in the solicitation. If any qualified Home and Community-based Services are not currently available to Medicaid recipients in the State (and are, therefore, not included in the State's maintenance of effort calculations), provide a detailed account of when and how they will be added to the Medicaid program. For HCBS demonstration services and supplemental demonstration services, indicate the billable unit of service and the rate proposed by the State. For supplemental demonstration services, provide any medical necessity criteria that will be applied as well as the provider qualifications.

***See Services Chart. (Appendix C)**

Qualified Home and Community Based Program Services

Brief descriptions of the 1915(c) waiver programs and state plan services that will be used in the MFP Demonstration program are identified below.

HCBS/FE - Waiver

- Fed/State Funding
- Population – 65 and older; functionally and financially eligible for Medicaid; eligible for nursing facility level of care

Services – adult day care, assistive technology, attendant care services (provider directed & self directed), nursing evaluation visit, personal emergency response & medication reminder, sleep cycle support, wellness monitoring, oral health services

HCBS-MR/DD Waiver

- Fed/State Funding
- Population – age 5 or older; meet definition of mental retardation or developmental disability; eligible for ICF/MR level of care; determined disabled by SSA; determined financially eligible
- Services – residential supports, day supports, medical alert, wellness monitoring, family/individual supports, temporary respite care, overnight respite care, personal assistant services, oral health services, supported home care, supported employment, sleep cycle support, assisted services

HCBS-PD Waiver

- Fed/State Funding
- Population – age 16 to 64 (those on the PD waiver at the time they turn 65 may choose to remain on PD waiver); determined disabled by SSA; determined financially eligible; because of

the presence of a physical disability, need assistance with activities of daily living; eligible for nursing facility care

- Services – personal assistant services, assistive services, personal emergency response system & installation, sleep cycle support, oral health services

HCBS –TBI Waiver

- Fed/State Funding
- Population – age 16-64 ; have traumatic, non-degenerative brain injury resulting in residual deficits and disabilities; eligible for in-patient care in a Brain Injury Rehabilitation Facility, individual must show capacity to make progress from rehabilitation in the form of Transitional Living Skills; determined disabled by SSA; determined financially eligible
- Services – transitional living skills, assistive services, personal emergency response system & installation, personal services, sleep cycle support, behavioral therapy, cognitive rehabilitation, drug and alcohol therapy, speech & language therapy, oral health services
- Extended SPA Services include physical and occupational therapy

State Plan Services

Targeted Case Management (TCM) for all waivers that are part of MFP

- Frail Elder Waiver TCM
- MR/Developmental Disability Waiver TCM
- Physical Disability Waiver TCM
- Traumatic Brain Injury TCM

Additional Services MFP participants may qualify for, but are NOT MFP services:

Older Americans Act

- Fed/State Funding
- Population – 60 and older
- Services – homemaker, chores, attendant care, case management, nutrition services, caregiver support

Senior Care Act

- State funding (sliding fee scale)
- Population – 60 and older
- Services – attendant care, case management, chores, food supplements, home health, homemaker, Medicaid issues, mobility aids, personal emergency response, respite care, repairs/maintenance/renovations, transportation

HCBS Demonstration Services

Unit/Cost of Service

Transition Service (Individual Start Up Costs)

Direct costs incurred by the individual accessing MFP demonstration project related to their accessing community residential housing. Such costs would be identified as but not limited to: housing & utility deposits (rent / lease / purchase costs not allowed). Purchase of basic furnishing, linens, cooking and eating equipment / utensils, and other basic living cost that are necessary.

Unit / Cost

FE	unit = once during lifetime of demonstration project	\$ 2500
PD	unit = once during lifetime of demonstration project	\$ 2500
TBI	unit = once during lifetime of demonstration project	\$ 2500
MR/DD	unit = once during lifetime of demonstration project	\$ 2500

Home Modifications (additional)

Direct costs for home modifications that are individually necessary to assure successful community living. Costs that are in addition to HCBS Waiver home modifications or exceed HCBS Waiver limitations.

Unit / Cost

FE	unit = once during lifetime of demonstration project	\$ 5000
PD	unit = once during lifetime of demonstration project	\$ 5000
TBI	unit = once during lifetime of demonstration project	\$ 5000
MR/DD	unit = once during lifetime of demonstration project	\$ 5000

Adaptive Equipment / Technology (additional)

Direct costs for adaptive equipment / technology that is individually necessary to assure successful community living. Costs that are in addition to HCBS Waiver home modifications or exceed HCBS Waiver limitations.

Unit / Cost

FE	unit = once during lifetime of demonstration project	\$2500
PD	unit = once during lifetime of demonstration project	\$ 2500
TBI	unit = once during lifetime of demonstration project	\$ 2500
MR/DD	unit = once during lifetime of demonstration project	\$ 5000

Therapeutic Support Services

Behavioral therapy supports and services that are delivered individually and are designed to identify, minimize & remediate behaviors that put the individual at risk of losing their current, or prevent continued on-going community living. These therapies may be single focused or delivered in combination whichever is determined to meet the individualized needs of the participant.

Unit / Cost

TBI	unit = hour	\$ 60	max 83 units
MR/DD	unit = hour	\$ 60	max 333 units

Sub service within the Therapeutic Support service:**Training Support / Supervision**

Supervision of / training for direct care staff that are implementing the Therapeutic Support Services. The training / supervision must be specifically designed for the therapeutic support / service that are individually implemented for a specific participant. The training support /supervision may not duplicate on-going direct care responsibilities, supervision or programmatic oversight. This service is not designed to provide basic disability education, training or in-service support. The service must support the delivery of on-going effective therapeutic support services that are designed to identify, minimize and remediate behaviors that put the individual at risk of losing their current, or prevent continued on-going community living.

Unit / Cost

TBI	unit = hour /	\$ 150 per unit / limitation	33 units over 365 days
MR/DD	unit = hour /	\$ 150 per unit / limitation	80 units over 365 days

HCBS Supplemental Services**Medical Necessity Criteria****Unit/Cost of Service****Qualifications of the Provider**

No additional criteria are tied to supplemental service eligibility- existing waiver eligibility will be used.

Existing provider qualifications apply for all supplemental services; no new provider qualifications will be added.

Community Bridge Building

An interdisciplinary team meeting with potential MFP participants to discuss the MFP program and explore community living options. The team will discuss with the individual their desire to return to the community & begin identifying individualized community support networks. An additional goal of the CBB team is to facilitate relationship building and improve community ties.

Unit / Cost

FE	unit = hour	\$ 45	max 6 units
PD	unit = hour	\$ 45	max 6 units
TBI	unit = hour	\$ 45	max 6 units
MR/DD	unit = hour	\$ 45	max 6 units

Transition coordination service

TC will work with the resident in pre-transition planning to evaluate suitability for the Money Follows the Person Demonstration. TC will identify the individual's hopes and dreams and work to assist individual in realizing their goal of moving into a community based setting. Activities will include: helping the consumer to identify and eliminate potential barriers that would prohibit transitioning to the community, helping to facilitate and develop natural support systems, and providing technical information to concerned family and friends upon the consumer's request/release of information.

Unit / Cost

FE	unit = hour /	\$ 45 per unit / limitation	48 units over 120 days
PD	unit = hour /	\$ 45 per unit / limitation	48 units over 120 days
TBI	unit = hour /	\$ 45 per unit / limitation	48 units over 120 days
MR/DD	unit = hour /	\$ 45 per unit / limitation	48 units over 120 days

6. Consumer Supports

Describe the process and activities that the state will implement to ensure that the participants have access to the assistance and support that is available under the demonstration including back-up systems and supports, and supplemental support services that are in addition to the usual HCBS package of services.

Please provide:

Education Materials

A copy of the educational materials used to convey procedures the State will implement in order for demonstration participants to have needed assistance and supports and how they can get the assistance and support that is available;

A draft of a transition guide has been developed. (Appendix E) This guide will be provided to individuals interested in transition from either a nursing facility or an ICF/MR. SRS and KDOA, with input from the marketing task team will modify and expand this guide to ensure it includes all necessary information. This brochure explains what MFP is and how to obtain additional information.

In addition, the state has a *Know Your Options Guide* which details services specific to seniors, including HCBS/ FE waiver services. Current informational guides for existing HCBS administered through SRS will also be part of the information available to explain the array of services that will be offered as part of our Money Follows the Person Demonstration. The marketing task team is reviewing current informational brochures and will have responsibility for development of any additional materials. This task team process will assure consumer and other stakeholder input into educational materials for MFP.

24-Hour Back Up Systems

A description of any 24 hour back up systems accessible by demonstration participants including services and supports that are available and how the demonstration participants can access the information (such as a toll free telephone number and/or website).

See 24 –Hour Back Up Systems, following pages. (p 50-54)

Fair Hearing / Complaint Grievance:

Whether or not a beneficiary is deemed eligible for waiver services, he/she may request a fair hearing. The Targeted Case Manager is responsible for informing the individual during the intake and assessment period of their rights and responsibilities, including information about complaints and the fair hearing process. This information is provided in written form and is also available in the waiver program's Policies and Procedures manual, which is available on the SRS web site. When a person does not agree with the decisions made by provider agencies the consumer may appeal the decision to SRS if they cannot work the issue(s) out with an agency representative. Participants have a right to a fair hearing before the state hearing officer if their request is received in writing within 30 days of receiving the Notice of Action that they are disputing. (Participant Rights and Responsibilities are on the back of the Notice of Action, in addition to the address of the Office of Administrative Hearings.)

In all cases when a consumer is dissatisfied with an agency decision and a Fair Hearing is requested, the participant may have legal counsel or other representation at the hearing. If a request for a fair hearing is received prior to the effective date of the Notice of Action, assistance may continue at the current level pending a decision; however, any overpayment from a continuation may be recovered if the decision is not in the participant's favor. If the participant is then dissatisfied with the fair hearing decision, they may request a review of the decision by the State's Appeals Committee (K.S.A. 75-3306; K.A.R. 30-7-75).

Kansas Statewide Emergency Backup Plan Essential Elements of Self-Direction

Emergency planning is an essential component of self-direction. The types of situations which constitute emergencies, the types of services required in emergency situations, and the types of informal, formal and assistive services available to individuals vary widely, which means that emergency backup plans will be as individualized as the people using them.

The levels of emergency backup provisions presented below, while providing necessary services, still reflect the philosophy of consumer choice. While adding additional layers of protection for the participant, it allows the consumer to develop and manage the plan that best fits his/her needs. The TCM is responsible for helping beneficiaries organize emergency plans, supplies, supports, and services.

Levels of Emergency Backup

Consumer health and safety, in the event of an emergency, shall rely upon the following hierarchy of backup protections. The levels vary by degree of emergency need. Generally a consumer will access these levels of backup in order, starting with Level 1. In case of extreme emergency, however, a consumer may need to go directly to Level 4.

1. Emergency backup planning as part of self-direction planning
2. Identification and organization of supports and services offered by informal support networks
3. Identification and organization of formal supports and services offered as respite, emergency, backup and fee-for-service
4. Emergency management services

Level 1: Consumer Plan of Care Emergency Backups

All consumer-directed service plans will identify emergency and backup supports and services using a specific document that will identify emergency and backup supports and services. These plans will include identification of people or provider agencies that have been engaged to provide critical, emergency, and backup supports and services as part of the individual service plan. Self-directed emergency backup plans will also identify any assistive service needs associated with emergency situations, and how those needs will be anticipated and met.

A copy of the form which will be used to document backup and emergency planning is attached. This form has been approved in form and substance for another Kansas program, W.O.R.K. (see p 36)

In addition, all consumers on the HCBS waivers included in MFP are offered a service that pays for installation and rental of personal emergency response units (PERS). These units provide an emergency button that when activated prompts an immediate responder via a speaker unit installed in the individual's home. The responder asks the individual about the situation and based on the consumer's response contacts the appropriate supports. The consumer provides names and contact

information for four people to be contacted in the event of PERS activation when the unit is installed. When necessary, the responder can also contact 911 on behalf of the individual.

Level 2: Informal Network

In the event that the backup providers listed in the individualized service plan are not able to provide backup as planned, consumers may reach out to their network of family, friends, and neighbors to provide interim supports. Most consumers already rely on family and friends to provide supports and services, and in the event of an emergency, informal supports and services play a large role in supporting critical needs for self –directing consumers.

Level 3: Enrolled Medicaid Provider Network

Within existing service definitions and reimbursement structures, providers are able to designate differential pay rates for in-home workers who are engaged in respite, emergency, or backup services. As part of Medicaid Home and Community Based Service plan development, providers will identify the specific service and support needs associated with emergency and backup services, and specify the pay structure available for workers engaged for emergency and backup purposes.

In building community capacity, one of the key components will be to re-purpose the services offered in institutional settings to meet critical needs in home and community settings. Identifying and eliminating regulatory, financial and other obstacles to supporting consumers' ability to access emergency, respite and backup services that may be available through medical providers and nursing facilities will be a key component in building an emergency and backup response system for consumers self-directing their care in their communities.

Level 4: Extreme Emergency Backup

Beyond the above-required emergency backup plans, and in the event of an extreme emergency, the following services can be utilized.

Adult Protective Services/ Critical Incident Reporting

In an emergency situation where there is possible abuse, neglect, and/or exploitation, Adult Protective Services (APS) can be contacted. There is a statewide toll free telephone number available 24 hours a day that receives and triages reports. Under Kansas law, service and support professionals, including TCM's, are designated mandatory reporters to the adult protective services system. If a case is opened by APS, it will be investigated until a safe resolution for the consumer is made. In addition, APS will investigate reports by any citizen that suspects abuse or neglect. This toll free number is widely published across the state.

Division of Emergency Management

In the event of a natural or man-made disaster, the Kansas Department of Emergency Management coordinates disaster relief through County Emergency Management Agencies. These regional offices in turn coordinate with community-wide organizations in the event of a disaster. Each state agency has in place contingency plans for their particular constituency in the event of fire, tornado, flooding, or terrorism. These plans include assisting individuals with disabilities with evacuation and/or continuity of critical services.

911

All consumers are advised to call the emergency telephone number 911 in the event of a crisis where health or safety is in immediate jeopardy.



**Money Follows the Person
Individualized Emergency Backup Plan**

Name: _____

Briefly describe your emergency back-up plan. This plan should include your steps if: (1) an attendant doesn't show up at a critical time; or (2) you are in a situation where you need another attendant. For instance, list the people you will call, including names and phone numbers. List plans for service animals or pets, list people to notify in case of any type of emergency (and how to reach them), and list your plans for disaster preparedness.

Contact list in case an attendant doesn't show up:

(List of attendants who will provide emergency care)

Who to contact	Contact phone number	Contact Address
1)		
2)		
3)		

Other plans in case of a critical need for attendant care or in case an attendant does not showup: _____

Contact list for support in emergency:

(List of who to contact to assist with decisions in an emergency)

Who to contact	Contact phone number	Contact Address
1)		
2)		
3)		

Special instructions in the event of an emergency:

Contact list in case of emergency/disaster:

(Examples: power outage, flooding, tornado, etc...)

Who to contact	Contact phone number	Contact Address
1)		
2)		
3)		

Other plans for emergency/disaster preparedness:

Contact list for care of service animals/pets:

(Examples of need: emergency/disaster, hospitalization, etc...)

Who to contact	Contact phone number	Contact Address
1)		
2)		
3)		

Other plans for care of service animals/pets:

Contact list of people who are authorized to help make decisions or sign documents for you:

(Examples: Legal Guardian, Representative Payee, etc...)

Who to contact	Contact phone number	Contact Address
1)		
2)		
3)		

Signature of Individual or Agency developing Emergency Back-up Plan

Signature_____

Date_____

7. Self-Direction (See Appendix A)

Appendix A is considered part of the Operational Protocol and is required for States using self direction for MFP demonstration participants. An electronic copy of the form is available at http://www.cms.hhs.gov/DeficitReductionAct/20_MFP.asp or can be emailed directly by your CMS project officer. CMS requires that adequate and effective self-directed supports are in place. Provide a description of the self direction opportunities under the demonstration before the Institutional Review Board (IRB) approval. In addition to completing Appendix A, please respond to the following:

Self-Direction Opportunities

All four of the 1915(c) waivers that will be utilized for MFP, under our demonstration authority, have the option for self-direction for individuals. (Frail Elderly, MR/Developmental Disabilities Waiver, Physical Disabilities Waiver, & Traumatic Brain Injured Waiver)

Kansas is recognized as a state with a strong self-directed service delivery model in place. Due to the leadership of strong stakeholder/advocacy groups, in 1989 Kansas passed a law requiring that all individuals over the age of 16 who receive personal care services from the state have the right to self-direct these services. Of the six Medicaid waivers Kansas offers, four Medicaid waivers allow program participants to self-direct their care. These programs permit participants to hire a worker of their choice and direct their own care or have a provider direct their care for them. The option to self-direct is chosen by 87% participants in the Physical Disabilities Waiver program, by approximate 80% participants in the Traumatic Brain Injury program, 33% participants in the MR/DD Waiver program, and 42% participants in the Frail Elderly Waiver program.

An assessment process is undertaken to determine the type and amount of services needed to support a consumer's health, safety and well-being in the community. Consumers that choose to self-direct their services are responsible for hiring, training, and supervising their own attendants and are required to sign up with a payroll agent to bill Medicaid. Any home health agency licensed by the Kansas Department of Health and Environment may provide attendant care services. Currently there are 308 licensed home health agencies in Kansas.

Kansas has completed the Kansas Personal Assistance Supports and Services (K-PASS) grant from the U.S. Department of HHS. This grant created a strong introduction, education and support "Toolkit" for use across waiver services. This toolkit is an additional resource for the enhancement of self-direction opportunities within Kansas.

In some rural areas of the state there are no home health agencies offering attendant care, so self-direction may be the only option for some consumers. Independent Living Counselors and Department of Social and Rehabilitation Services Performance Improvement Consultants continually educate consumers about both self-directed care and agency-directed care. The FY06 Department of Social and Rehabilitation Services contract with Community Developmental Disability Organizations (CDDOs) stipulates that each CDDO will ensure that individuals seeking or receiving services in its area are informed of the benefits and responsibilities of self-directed care.

Within the MR/DD system the Kansas Legislature passed the Developmental Disabilities Reform Act in 1994. This act put person centered support planning into statute. The Secretary of the Department

of Social and Rehabilitation Services had regulations written that developed a system that required person centered planning as the core of not only the planning process but as the primary criteria for granting a license to Community Service Providers. The primary required lifestyle areas are: where the person wants to live; with whom the person wants to live; day activities or employment the person wants; preferred social & leisure activities and development of relationships with family, friends and significant others. Within those lifestyle preferences provider organizations must address independence, productivity, personal integration and community inclusion.

HCBS/FE program recipients are provided the opportunity to self-direct Attendant Care. In choosing this option, the individual must select their attendant(s), collect basic information including a background check, refer the chosen attendant to a payroll agent for registration, and ensure the assigned hours are within the limits of the Plan of Care and Customer Service Worksheet. In addition, the individual must ensure continuous coverage including vacation and sick leave, provide the attendant with basic instruction and training on general duties, maintain time sheets for each attendant and forward to the payroll agent, handle issues or problems that may arise, and notify the Case Manager of any changes in medical condition, eligibility, or changes in circumstances that may affect services.

SRS and KDOA will develop a consortium of state agencies, private resources and advocates who will work to build community capacity. These efforts will focus on identification of needed education, training, as well as necessary or required levels of pay and benefits for attendant care/direct care workers. This will be done to assure that beneficiaries have ready access to high quality support staff. The consortium will develop recommendations for the funding necessary to create good wages and benefits, including health insurance for workers. A desired outcome is attendant care/direct care work will become a viable career opportunity for workers.

The Demonstration and Supplemental Services identified in the MFP demonstration grant focus a large portion of the dollars on the development of a well trained and compensated work force. Additionally, Kansas is the recipient of a 2006 Real Choice Systems Transformation grant. This project focuses heavily on the funding of the state LTC system. Assessing the state's funding structure, identifying the true costs of services, and ensuring the availability of trained, appropriately compensated workers are all features of this joint, state/federal project. Implementation of the Systems Transformation grant's recommendations will positively impact the availability and quality of services.

Voluntary Termination of Self-Direction

Describe how the State accommodates a participant who voluntarily terminates self-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 self-direction to the alternative service delivery method.

Voluntary Termination

One of the consumer's opportunities as well as responsibilities is the ability to discontinue the consumer-direct option. At any time, if the consumer chooses to discontinue the consumer-direct option, he/she is to:

- notify all providers as well as the payroll agent. The consumer is to maintain continuous attendant coverage for Personal Services and/or Sleep Cycle Support with the authorization for service;
- give ten (10) days notice of his/her decision to the Targeted Case Manager to allow for the coordination of service provision.

The duties of the Targeted Case Manager are to:

- explore other service options and complete a new Consumer Choice form with the consumer;
- advocate for consumers by arranging for services with individuals, businesses and agencies for the best available service within limited resources.

Involuntarily Termination of Self-Direction

Specify the circumstances under which the State will involuntarily terminate the use of self-direction and thus require the participant to receive provider-managed services instead. Please include information describing how continuity of services and participant health and welfare will be assured during the transition.

Involuntary termination of the self-directed option may occur only as outlined in Appendix A, section III, item M for each waiver. Appendix A for each waiver is included with this operational protocol.

Self-Direction Demonstration Goals

Specify the State's goal for the unduplicated number of demonstration participants who are expected to avail themselves of the demonstration's self direction opportunities.

The decision to self-direct services can only be made by the individual/LAR. Kansas will educate, explain, and offer the option of self-directing services to every MFP participant. As noted in **Appendix A**, Kansas estimates that 486 individuals will participate in one of the self-direction options. Break out by population is as follows:

Frail Elders- 106
 MR/Developmental Disabilities- 29
 Physical Disabilities- 311
 Traumatic Brain Injury- 40

8. Quality

Provide a description of the State's quality management system (QMS) for demonstration participants during the demonstration year and a description of what system they will be transitioned to after the 12-month demonstration period. Regardless of the financing and/or service delivery structure proposed under the demonstration, states must demonstrate how services during the 12-month transition period will:

- Be utilized to inform the CMS evaluation of the state's MFP demonstration; and***
- Meet or exceed the guidance for a QMS set forth under Appendix H of the 1915(c) HCBS waiver program.***

Description of Kansas' Quality Management System

Kansas currently utilizes approved Appendix H for the following 1915(c) waivers. The State is responsible for a quality management system consistent with the six waiver assurances and the three additional assurances for all long term care services received by MFP participants.

Medicaid waivers that are included in our MFP demonstration:

Physical Disability Waiver (PD)
MR/Developmental Disabilities Waiver
Traumatic Brain Injury Waiver (TBI)
Frail Elderly Waiver (FE)

As required for the Money Follows the Person demonstration project, state staff are responsible for implementation of existing quality management activities with 100% of MFP participants. A brief description of our CMS approved Kansas Quality Management strategy is provided below. The KQMS provides oversight, monitoring and continuous improvement strategies in accordance with the separation of Quality Assurance and Quality Improvement functions defined by the State of Kansas. This separation, in combination with the CMS Home and Community-Based Services (HCBS) Quality Framework serves as the driving force for systems with regard to health and safety assurances, as well as, continual systems improvement to promote and assure quality of life.

This approach provides Kansas participants the opportunities to directly impact and move the service system in a manner which truly defines participant-centered approaches and outcomes. The Quality Improvement system is data-based and outcome-focused. The system provides for data-based decision making to improve the individual lives of each participant while pro-actively building statewide capacity. The KQMS is a two-prong approach utilizing identification minimum standard compliance and assurance of corrective action to address systematic weaknesses while simultaneously utilizing the data to identify best practices to promote participant independence, productivity, community inclusion and opportunities for systems improvement to promote participant quality of life.

The Targeted Case Manager (TCM) is responsible for initial development and revision of an Individualized Plan of Care, as needed and at least annually, to identify and address all supports and services necessary to meet the health, safety, risk, and personal goal needs with each participant and support team members chosen by the participant. The TCM is responsible for providing each participant will all available options for receiving and self-directing their services including

identification of future opportunities and planning to achieve the participant's choice of service options.

Each waiver service provider is responsible to develop person centered support plans and services in accordance with the lifestyle preferences of the person receiving the services. The providers are required to develop, implement, and revise person centered support plans, risk management assessments, and backup plans. Providers are informed of all quality and performance improvement performance indicators / performance standards and receive regular updates as to their performance levels. Corrective Action Plans are requested as determined necessary.

The Quality Survey Process includes assurance of services and supports based on need and choice of the participant and the participant's family; choice of institutional, community provider options and/or self-directed services; and changes in eligibility and preferences. Additionally, these choices are documented with the consumer / guardian signature and placed for review in the case file / individual file and reviewed during the Quality Survey Process.

State staff (*Regional Field Staff – Quality Assurance*) conduct Quality Survey reviews in accordance with the Quality Survey Process to review for and address any identified occurrences of non-compliance with regulatory standards and minimum performance standards. State staff also verifies service providers meet required licensure and certification standards prior to furnishing waiver services through the policy approval process. Review of qualified providers is conducted through the on-site monitoring process and the licensing process which is included in the Quality Survey Process and were developed in Kansas by consumers, stakeholders, and the waiver operating agency.

Kansas Health Policy Authority (KHPA), the single state Medicaid agency and Social and Rehabilitation Services (SRS), and Kansas Department on Aging (KDOA) work together to develop a state operating agency priority identification regarding all waiver assurances and minimum standards / basic assurances.

Data gathered by regional staff during the Quality Survey Process is provided quarterly to the DDBHS/CSS Performance Improvement Review Committee for evaluation and trending to identify areas for improvement. Upon completion of identified areas of improvement this information is compiled into an executive report (quarterly and annually) which is submitted to the Performance Improvement Executive Committee.

The KQMS Flow Diagram illustrates how the State of Kansas meets CMS assurances and the KQMS Reporting /Communications diagram provides the quality assurance and continuous improvement approaches in place.

(See charts on p 62-64)

a. If the State plans to integrate the MFP demonstration into a new or existing 1915(c) waiver or HCBS SPA, the State must provide written assurance that the MFP demonstration program will incorporate, at a minimum, the same level of quality assurance and improvement activities articulated in Appendix H of the existing 1915(c) HCBS waiver application during the transition and during the 12 month demonstration period in the community. The state need not provide documentation of the quality management system already in place that will be utilized for the demonstration. But, rather provide

assurances in the OP that:

i. This system will be employed under the demonstration; and

ii. The items in section (C) below are addressed.

In addition, the state should provide a brief narrative regarding how the existing waiver QMS already or will be modified to ensure adequate oversight/monitoring of those demonstration participants that are recently transitioned.

MFP Assurances

a. Kansas will assure that the MFP Demonstration will meet the existing level of quality assurance and improvement activities of the current 1915(c) waivers. Our MFP Demonstration will utilize existing 1915(c) waiver quality assurance processes as currently approved by CMS.

ai. Kansas will assure that the same level of quality assurance and improvement activities as articulated in Appendix H will occur for the existing 1915(c) waivers during the transition and during the 12 month demonstration period.

a.ii. Regarding items in section (c), below, Kansas assures that the same level of quality assurance and improvement activities as articulated in Appendix H will occur for all demonstration and supplemental services that are part of Money Follows the Person. Kansas can assure that the quality assurance process of its current 1915(c) CMS approved waivers have adequate remediation and improvement processes.

If the State plans to utilize existing 1915(b), State Plan Amendment (SPA) or an 1115 waiver to serve individuals during and after the MFP transition year, the State must provide a written assurance that the MFP demonstration program will incorporate the same level of quality assurance and improvement activities required under the 1915(c) waiver program during the individual's transition and for the first year the individual is in the community. The state must provide a written narrative in this section of the OP regarding how the proposed service delivery structure (1915(b), SPA, or 1115) will address the items in section (c) below.

1915(b), State Plan Amendments, or 1115 Waivers.

Kansas will not use any Medicaid 1115 waivers, 1915(b) or state plan amendments for purposes of this MFP Demonstration.

b. The Quality Management System under the MFP demonstration must address the waiver assurances articulated in Appendix H of the 1915(c) HCBS waiver application and include:

i. Level of care determinations;

ii. Service plan description;

iii. Identification of qualified HCBS providers for those participants being transitioned;

- iv. Health and welfare;***
- v. Administrative authority; and***
- vi. Financial accountability.***

The 1915(c) waivers that will be used as part of Money Follows the Person, under our demonstration authority, meet all of CMS assurances and have been approved by CMS. For further detail please see chart on pages 56-58.

c. If the State provides supplemental demonstration services (SDS), the State must provide:

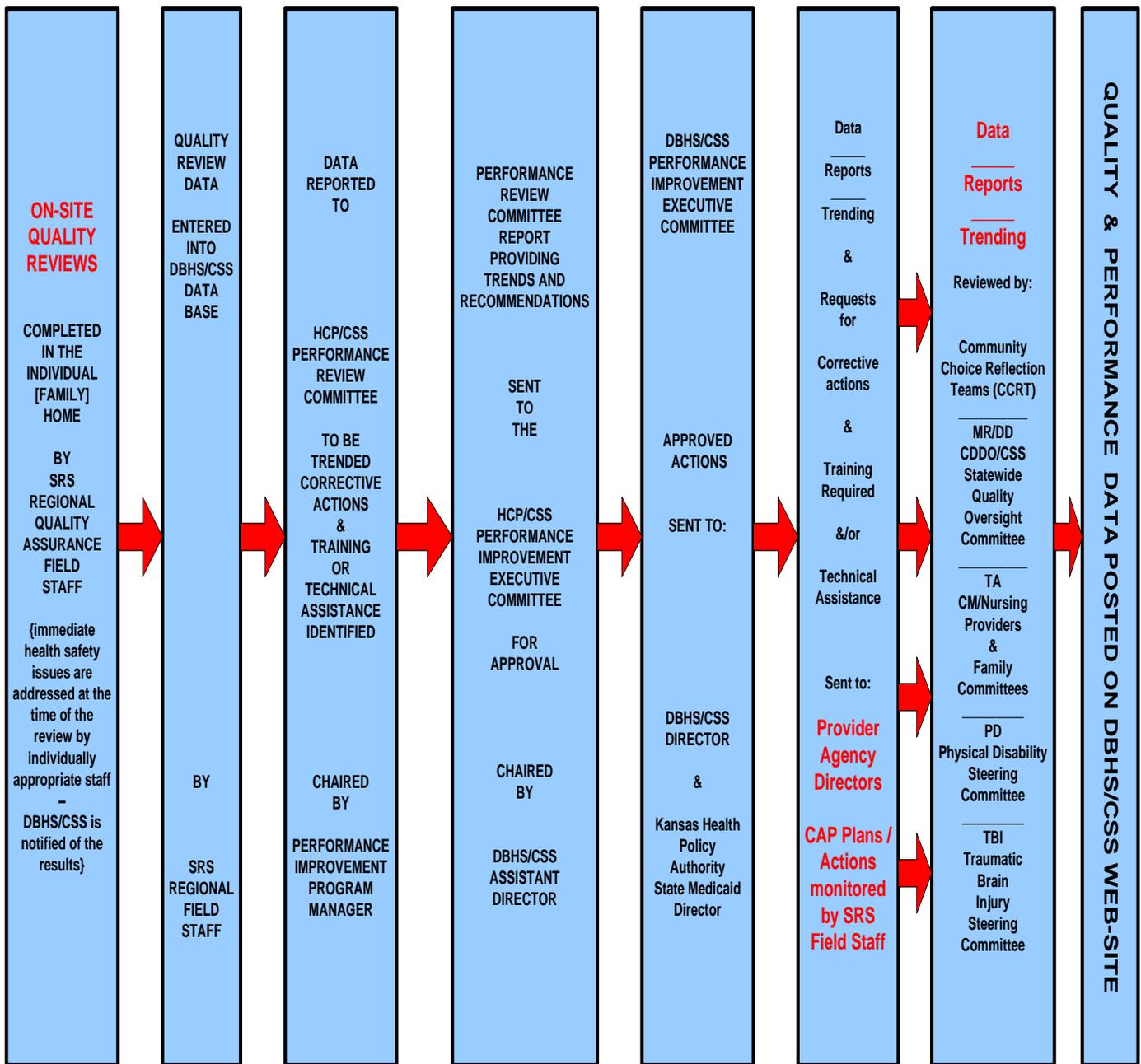
- 1. A description of the quality assurance process for monitoring and evaluating the adequacy of SDS service(s) to manage the barrier it was selected to address; and,***
- 2. A description of the remediation and improvement process.***

Our existing approved quality management system will incorporate supplemental demonstration services, which includes a process for monitoring the adequacy of the SDS service in relation to the barrier it is to address and a process for remediation and improvement. This will be achieved by including a review of all SDS services on documents that are used for current quality assurance & program improvement processes. In addition, all quality enhancement coordinators and program improvement staff will be trained on MFP to ensure they include supplemental demonstration services in their quality assurances activities.

KANSAS QUALITY MANAGEMENT STRATEGY REPORTING / COMMUNICATIONS

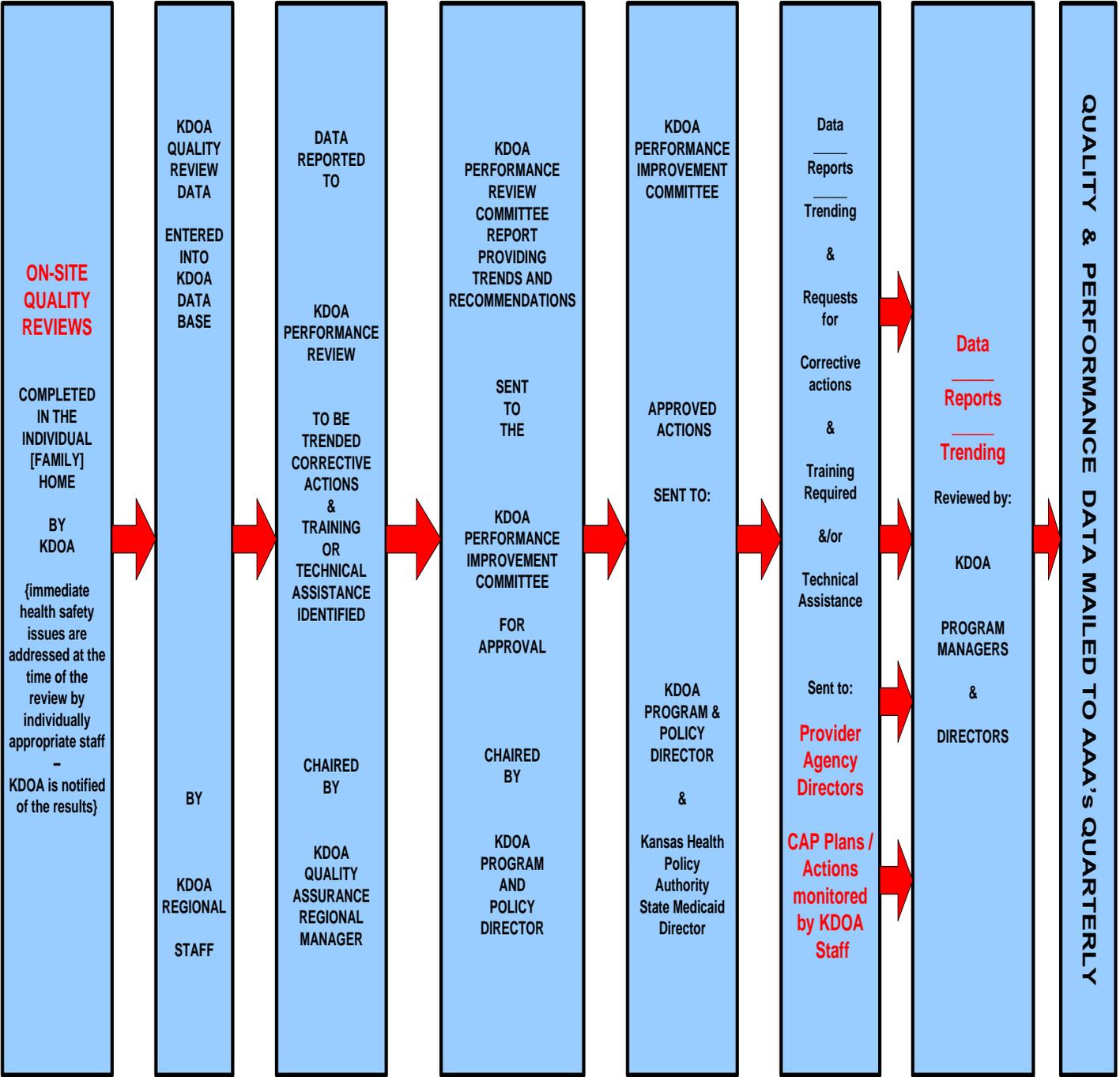
SRS / Division of Disability & Behavioral Health Services

Community Supports & Services

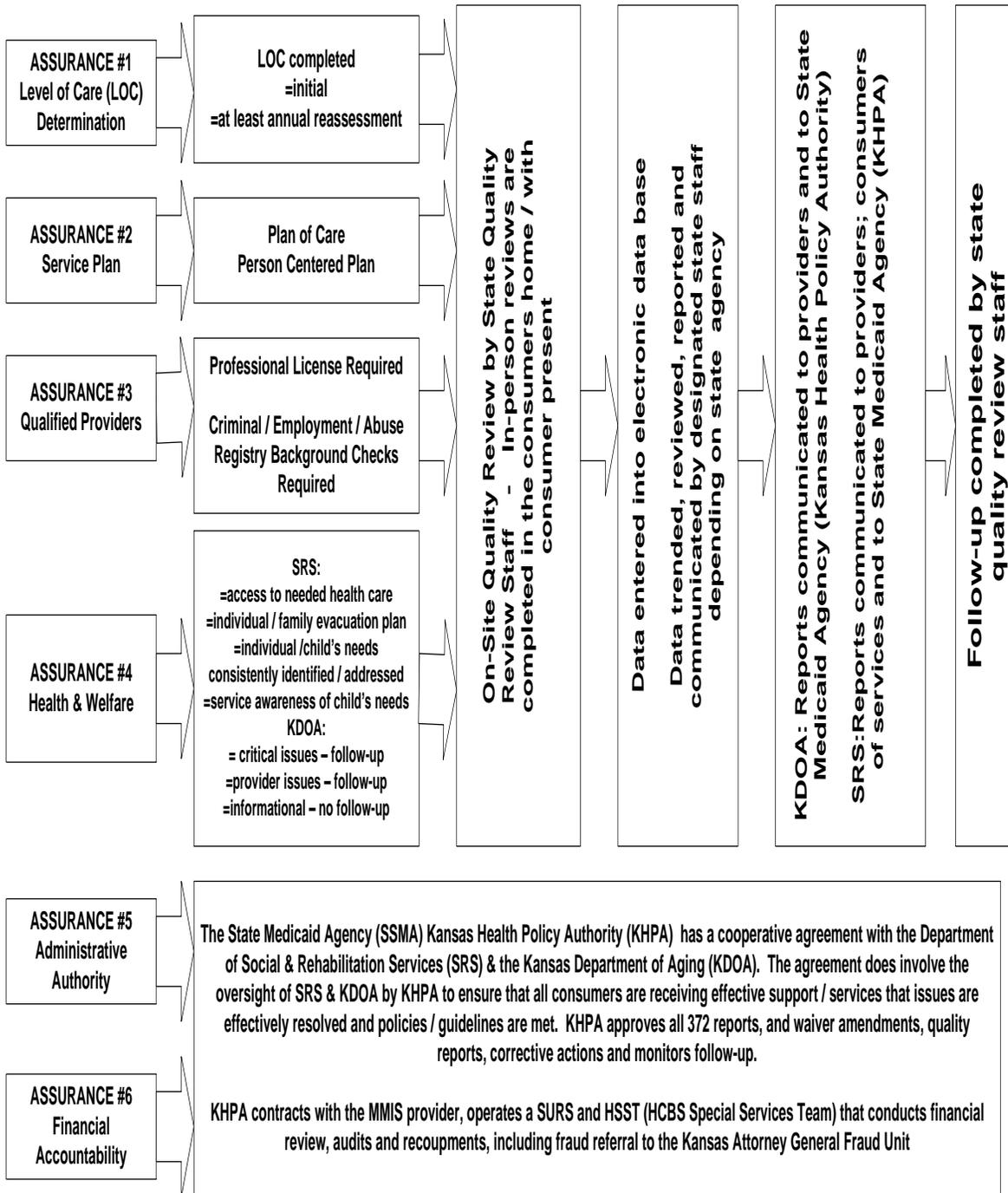


KANSAS QUALITY MANAGEMENT STRATEGY REPORTING / COMMUNICATIONS

Kansas Department on Aging



KANSAS QUALITY MANAGEMENT STRATEGY FLOW DIAGRAM



9. Housing

a. **Describe the State's process for documenting the type of residence in which each participant is living (See chart for examples in Appendix B). The process should categorize each setting in which an MFP participant resides by its type of "qualified residence" and by how the State defines the supported housing setting, such as:**

- i. **Owned or rented by individual,**
- ii. **Group home,**
- iii. **Adult foster care home,**
- iv. **Assisted living facility, etc.**

If appropriate, identify how each setting is regulated.

Documentation of Qualified Residence

Information on the type of qualified residence that an individual chooses is verified at the time the participant is enrolled in a 1915(c) waiver. This information can be accessed from the Universal Assessment Instrument or the BASIS assessment. The Universal Assessment Instrument (UAI) determines functional eligibility for the FE, PD, & TBI waivers. A BASIS assessment is used to determine functional eligibility for the MR/DD waiver.

Kansas assures that MFP Demonstration participants will move into housing settings that meet the definition of a "qualified residence" as defined in Section 6071(b) (6) of the Deficit Reduction Act.

Money Follows the Person eligible participants in Kansas may transition to one of the following a qualified residences.

- i. A home owned or leased by the consumer. Independent housing means a house or apartment that is owned or leased by the individual or the individual's family member.

Covered Population in the MFP Grant: Frail Elderly (FE), Physically Disabled (PD), Traumatic Brain Injury (TBI) and Mental Retardation/Developmental Disability (MR/DD).

Regulatory Oversight: Housing is regulated in Kansas by a network of federal, state and local resources, including the Department of Housing and Urban Development, local Public Housing Authorities, Fair Housing and Equal Opportunity agencies, the Kansas Housing Resources Corporation, and state landlord/tenant laws.

- ii. An apartment which an individual leases with lockable access and egress, and includes living, sleeping, bathing, and cooking areas over which the individual or family has domain and control.

Covered Populations in the MFP Grant: FE, PD, TBI, MR/DD

Regulatory Oversight: Housing is regulated in Kansas by a network of federal, state and local resources, including the Department of Housing and Urban Development, local Public Housing Authorities, Fair Housing and Equal Opportunity agencies, the Kansas Housing Resources Corporation, and state landlord/tenant laws.

- iii. 4 Bedroom Residential Homes-means living in a home or home setting with a limit of no more than 4 unrelated residents residing in the home. There is a provision of assistance and supports in the home and the community for the consumer. Supportive services may include personal care, assistance with activities of daily living, supervision, medication reminders, as well as supportive services

Covered Populations: MR/DD

Regulatory Oversight: These homes are licensed by Social and Rehabilitation Services of Kansas (Group Home), or by Kansas Department on Aging (Residential Care Home).

b. Describe how the State will assure a sufficient supply of qualified residences to guarantee that each eligible individual or the individual's authorized representative can choose a qualified residence in which the individual will reside.

Assurance of Sufficient Supply of Qualified Residences

A key community capacity issue for many residents is the availability of affordable, accessible housing in local communities. Most housing resources for the state are channeled through the Kansas Housing Resources Corporation (KHRC). KHRC has been a supportive partner in developing and committing resources towards creating affordable, accessible housing across the state. Engaging KHRC, local public housing authorities and private housing developers and providers will be integral to building this vital community resource.

Kansas uses available resources to promote the availability of integrated, accessible, affordable housing by promoting housing development and through encouraging rehabilitation and modification of existing housing stock. KHRC is a responsive partner in efforts to address housing concerns and development issues throughout the state. SRS and KDOA will partner with KHRC to address housing issues related to transitioning individuals into community settings from qualified institutional settings.

Community partners will support the development, rehabilitation and modification of housing at the local level. As part of ongoing advocacy efforts designed to promote community living, education and advocacy for the development of rehabilitation and accessibility modification resources will continue. Public/private partnerships and support for additional resources such as "targeted housing vouchers" will assure the availability of integrated, accessible, affordable housing for all people returning to the community. As an integral and well-educated resource for transition planning, Targeted Case Managers will also be a resource for locating housing options.

- i. **Describe existing or planned inventories and or need assessment of accessible and affordable community housing for persons with disabilities and chronic conditions.**

The Kansas Housing Resources Corporation maintains lists and registries of a variety of housing options around the state, and is always seeking to promote better information-sharing and access to housing resources. Kansas originally proposed to create a housing inventory as part of Money Follows the Person. However, in the months since the proposal was written KHRC has developed a mechanism for tracking affordable community housing options. As part of our proposed benchmarks we intend to evaluate this website and provide feedback on any recommended modifications to improve this tracking mechanism. The website states: *“Welcome to KSHousingSearch.org where it's FREE to list and search for properties. This is a new service, and properties are being added daily, so check back often. If you know of a property provider with housing to list, have them contact us!”*

The website can be found at:

<http://www.kansashousingsearch.com/>

This website identifies accessible housing options and is updated at least every 10 days. Landlords can independently update the site at any time to indicate a new vacancy or to show that a vacancy has been filled. KHRC is continuing to encourage participation from landlords across the state on the Kansas Housing search website. In many rural areas case managers will identify alternative means to locate housing. These efforts will include contacting local housing authorities who often maintain info on vacancies, working with housing specialists at the local CIL who also maintain information about accessible units and the traditional means of looking in the newspaper or other local publications for rental properties.

Ongoing efforts to educate homebuilders and developers will partner with KHRC to evaluate community needs and encourage the development of housing that meets the needs of residents with disabilities. These efforts are occurring in local communities, often initiated by CIL's. These efforts vary by area are not formally initiated by MFP staff. Developers will be encouraged to provide more than the federally-required minimum of accessible units; KHRC can help create incentives for developers accessing Housing Trust Fund resources and Low Income Tax Credits. Local agencies will continue to advocate within their communities and will also refer local housing providers to KHRC for information on additional resources, including Low Income Tax credits.

In addition, KHRC publishes architectural standards for single- and multi-family dwellings, along with architectural drawings. The Qualified Allocation Plan for the Housing Tax Credit Program includes up to 20 points for developments in which 100% of the units are targeted to tenants 55 years and older and/or to tenants with special needs. Priority is given to applications for "any development for special needs populations including, but not limited to homeless families and individuals or persons with disabilities." Developments of single-family, duplex and triplex homes are required to meet the requirements of K.S.A. 2002 Supp. Chapter 58-1401 through 58-1407. KHRC's HOME Rental Development program uses the same architectural and development standards and works with some Community Housing Development Organizations that develop housing specifically for persons with disabilities. Developers generally focus their applications where they believe there is need, making it more likely their applications will be rated favorably. The timeframe for the strategy is ongoing, with the allocation plan updated every year, based on what is believed to be current need. Because the Housing Tax Credit and HOME Rental applications are competitive and market-driven, KHRC must be aware that its allocations enable housing that is marketable.

Using the results from the MDS, identifying the communities where residents have identified a desire to return to the community in Section Q, it should be possible to cross-reference the housing

resources provided by KHRC to evaluate the housing needs, ability to meet those needs, and places where additional efforts to develop housing are needed to support community living.

For many individuals with intellectual disabilities there is an additional housing option. Our existing network of service providers on the MR/DD waiver own properties and rent these back to the individuals at an affordable rate. It is common that part of the community capacity efforts for local providers is increasing their stock of housing so that a place to live is not a barrier to community living. In addition many providers have worked to establish relationships with local rental agencies which offer affordable rentals to individuals with developmental disabilities.

ii. Explain how the state will address any identified housing shortages for persons transitioning under the MFP grant

Identified housing shortages will be addressed using a variety of approaches: rehabilitation and retrofitting of available housing stock; development of new housing stock, and assistance with exploring all housing options. In Kansas, the vast majority of people who move into nursing facilities were transferred immediately from the hospital. These residents likely had a home and community prior to going into the hospital; exploring ways to retrofit and modify housing of origin by using emergency repair and accessibility modification funds are one way to address housing shortages.

Kansas has effectively used Low Income Tax Credits to encourage the development of new housing stock. KHRC controls the “scoring” for proposed projects under this program. KHRC should be encouraged to adopt scoring standards that will encourage building more accessible units, targeting communities where housing needs are especially pressing, and that set aside housing for people transitioning from institutions back to their communities.

Several Kansas communities have adopted “homeless” equivalencies for people who are living in nursing facilities. Under this system, these communities have associated community transition with other imminent, emergent housing need conditions, to express a preference for housing options, including Section 8 housing vouchers. The state can encourage the use and application of homeless equivalency definitions to promote the availability of resources to obtain affordable housing. So, though many Kansas communities do have waiting lists for subsidized housing this is one strategy to minimize this barrier for MFP participants.

Finally, enforcing existing access laws in the state, including Section 504 federal compliance and compliance with Kansas’ “visitability” law, which applies universal design requirements to housing developed using federal funds in the state, will help to ensure that the development and initiatives undertaken to promote affordable, accessible housing will meet the basic access needs of all individuals.

iii. Address how the State Medicaid Agency and other MFP stakeholders will work with the Housing and Finance Agencies, Public Housing Authorities and the various housing program they fund to meet these needs.

As previously stated SRS and KDOA will partner with KHRC, entitlement communities and local public housing authorities to address housing issues related to transitioning individuals into community settings from qualified institutional settings. We have formed a Housing Task Team as a sub-group of our MFP Steering Committee. This task team will focus on activities related to housing

and successfully completing our housing related benchmarks. Task team members include consumers, stakeholders, advocates, and state staff persons. We will continue to network with state housing officials and local providers to expand membership on this task team and to solicit feedback on how to improve community housing options for persons with disabilities and seniors across our state. Specific activities include:

- Support development & dissemination of training materials for appropriate staff and housing developers on current housing law and acts that address accessible housing. (504, FHAA and visitability)
- Support KHRC expansion of Housing Trust Fund resources; apply federal requirements for fully accessible set-asides to Housing Trust Fund resources and advocate for full compliance with state laws governing universal design.
- Promote the use of mainstream housing vouchers and priority status “set asides” for access to public housing units and housing vouchers for individuals leaving institutions as a homelessness equivalency on the state and local levels
- Explore the possibility of local housing authorities applying for transitional housing vouchers that could be specific for MFP participants as a short term solution as individuals leave institutions and then eventually move to the mainstream housing voucher programs.

iv. Identify the strategies for the State pursuing to promote availability, affordability or accessibility of housing for MFP participants.

The core strategy for promoting the availability of affordable, accessible housing is to develop and promote resources that support such housing. In the past, advocates and consumers have been able to support local housing authorities’ application for “mainstream” housing vouchers, to secure vouchers specifically targeting people transitioning into the community. Continued work with local housing authorities can promote the use of these vouchers to support MFP candidates in successfully transitioning into the community.

Programs such as the Kansas Accessibility Modification Program (KAMP), a housing trust-fund program, provide resources from the state to local communities to provide funding for accessibility modifications to existing housing stock, so that people can remain in their own homes. Expanding the statewide program to make resources available to developers can encourage the creation of accessible housing stock other than housing currently occupied by people requiring access features. It is also possible to replicate and encourage replication of the statewide KAMP on local levels. At least one entitlement community in the state has an accessibility modification program available to residents, to support community living. Housing resources could be tied to individual MFP candidates to ensure that needed access features for housing could be obtained to support community transition.

Resources can also be leveraged through creative funding such as modifying state access tax credits to allow non-owner-occupied housing providers to use state tax credits to make existing housing accessible, or to incorporate more than the minimum number of accessible units into new construction. Low Income Tax Credit projects can be rewarded or scored higher when they “set aside” specific units for MFP participants.

In addition to housing, transportation, especially for people living in rural communities, represents one of the greatest barriers for community living. Organizations ranging from APRIL to NCIL identify transportation as a public policy priority year after year. In particular, inter-city travel represents a challenge. The regionalization of health care and the lack of infrastructure and resources within small communities point to a need for the development of public and private resources to address transportation issues in support of community living. Therefore, in addition to looking at housing issues, our housing task team will continue to work to improve the dissemination of information about options for expanding transportation options within local communities.

10. Continuity of Care Post the Demonstration.

To the extent necessary to enable a State initiative to meet the demonstration requirements and accomplish the purposes of the demonstration, provide a detailed description of how the following waiver provisions or amendments to the State plan will be utilized to promote effective outcomes from the demonstration and to ensure continuity of care:

Continuity for Demonstration MFP Participant

Kansas has methodically worked with stakeholders to develop its long-term services and supports system to include community-based programs and services to meet the needs of individuals who want to remain in their communities. 1915(c) waiver services were carefully selected in order to promote community living and to ensure a successful relocation.

MFP Demonstration participants will be accessing services that mirror established 1915(c) waivers, which the state will provide under our demonstration authority. In the post demonstration period, participants will transition to existing 1915 (c) waivers as long as they continue to meet the eligibility criteria. Eligibility and assessment tools are identical for the demonstration project as the established 1915(c) waivers. Therefore, there will no lapse in services for MFP Demonstration participants and a transition plan is not required.

After the MFP Demonstration period, if an individual does not meet the institutional level of care requirement or medical necessity, that individual would not be eligible to participate in any of the Medicaid 1915(c) waiver programs. This can only occur if an individual's level of care score had changed, because eligibility and assessment processes are the same for services offered during the demonstration period and for services offered on the 1915 (c) waiver. However, if the individual met Medicaid financial eligibility, and the functional eligibility criteria for Kansas' state plan programs, then the state will assist that individual in the enrollment of one of those programs. If Medicaid financial eligibility is not met, the individual will be assessed to determine eligibility for services available under the Older American Act or programs, and/or Kansas' state general funded services.

Home and Community-Based (Section 1915(c)) – for participants eligible for “qualified home and community-based program” services, provide evidence that:

- i. Slots are available under the cap;***
- ii. A new waiver will be created; or***
- iii. There is a mechanism to reserve a specified number of slots via an amendment to the current 1915(c) waiver.***

All necessary waiver slots are currently available or have been budgeted for in Kansas. Though our waivers do allow for waiting lists MFP participants will by-pass any waiting lists. MFP demonstration participants are assured services on the existing 1915 (c) waivers upon completion of their 365 days of demonstration services. There will be no waiting lists for any person transitioning from MFP to existing waiver programs/services.

No new waiver will be created. All MFP participants will transition from a qualified institution back to the community with long-term services and supports provided under our demonstration authority which mirror the existing 1915(c) Medicaid waivers. Services will continue for MFP participants as long as they desire to remain in the community and meet the eligibility criteria.

No new 1915(c) waivers will be created.

a. Research and Demonstration (Section 1115) – for participants eligible for the research and demonstration waiver services, provide evidence that:

i. Slots are available under the cap;

ii. A new waiver will be created; or

iii. There is a mechanism to reserve a specified number of slots via an amendment to the current Section 1115 waiver.

Research and Demonstration

Section 1115 waivers will not be utilized for the MFP Demonstration.

b. State Plan and Plan Amendments - for participants eligible for the State plan option services, provide evidence that there is a mechanism where there would be no disruption of care when transitioning eligible participants to and from the demonstration program

State Plan and Plan Amendments

As noted above, MFP demonstration participants will transition to the appropriate Medicaid 1915(c) waiver as long as they meet the program requirements and wish to retain services.

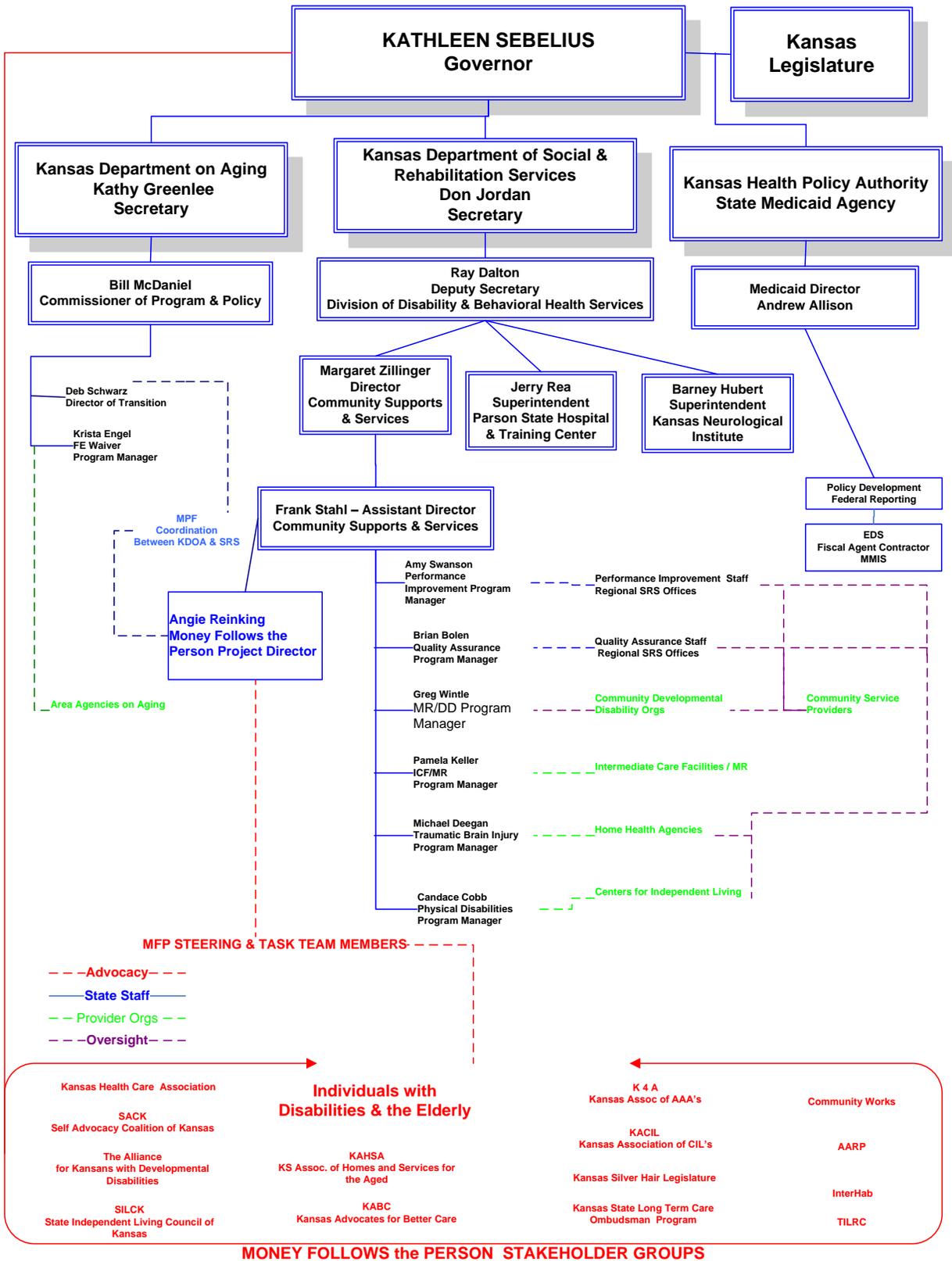
C. Organization and Administration

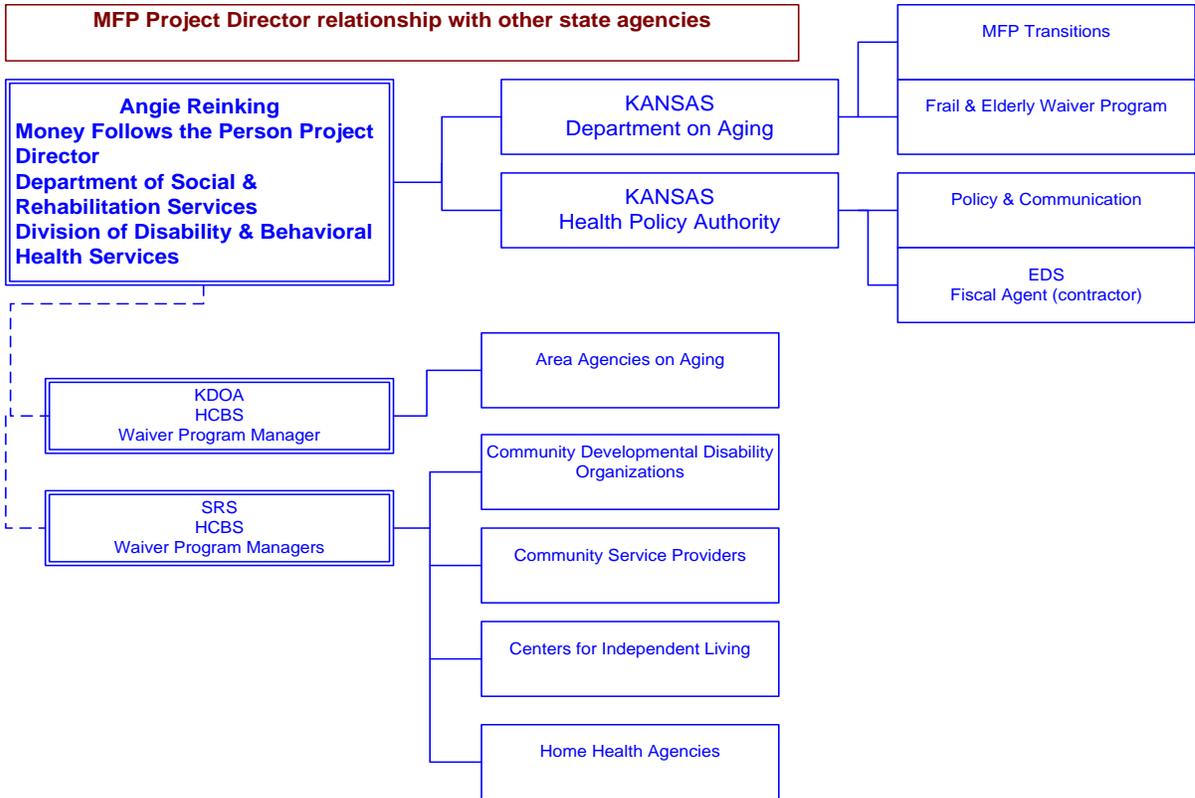
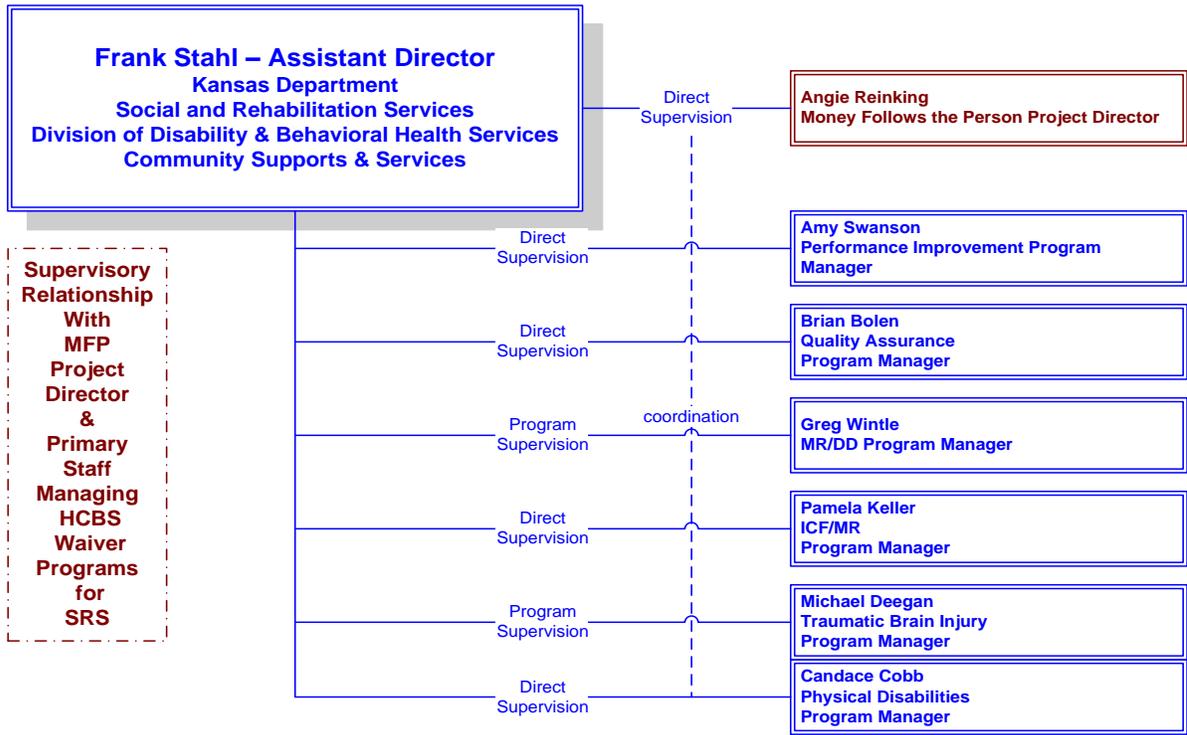
Provide a description of the organizational and structural administration that will be in place to implement, monitor, and operate the demonstration. Please include the following:

1.Organizational Structure: Provide an organization chart that describes the entity that is responsible for the management of this grant that how that entity relates to all other departments, agencies and service systems that will provide care and services and have interface with the eligible beneficiaries under this grant. Show specifically the relationship of the organizational structure to the Medicaid Director and Medicaid agency.

The organizational chart clearly shows where MFP project director sits/to whom her/she reports.

(See attached charts on following pages)





Billing and Reimbursement Procedures

Describe procedures for insuring against duplication of payment for the demonstration and Medicaid programs; and fraud control provisions and monitoring.

Kansas uses the MMIS claims processing system to verify that the participant was Medicaid-eligible on the date of service delivery specified in the request for reimbursement and allows payment only on claims for services provided within the eligibility period.

Prior to processing claims, the automated claims management system edits claims for validity of the information and compliance with business rules for the service/program, and calculates the payment amount and applicable reductions for claims approved for payment. For example, unless the system verifies that a participant's current authorized plan of care has sufficient units in the plan of care to cover amounts claimed or that an authorized level of care is registered in the claims management system, the claim will be rejected.

Kansas uses a fiscal review process to ensure that providers for the various Medicaid 1915(c) waivers are complying with program requirements. The methods used in the fiscal review process include: examination of financial and service records as well as plans of care and other records; comparison of provider billings to service delivery and other supporting documentation.

Current procedures provide for on-site fiscal reviews to examine the provider agency's service delivery and financial records and verify that all payments made to the provider agency were supported with documentation. Typically, a one-month sample of the provider's records are reviewed unless an increase in the review is deemed necessary. Examples of records reviewed include assessment documents, service delivery documents, and complaints.

The provider must maintain documentation that supports the claims. If the provider fails to maintain the required documentation, all improper payments are recovered. The State also recovers payments when it verifies the provider was overpaid because of improper billing. The state may take adverse action against the provider's contract or require a corrective action plan for any fiscal review finding.

Staffing Plan: Provide a staffing plan that includes:

- a. A written assurance that the Project Director for the demonstration will be a full-time position and provide the Project Director's resume. Project director resume can be found at the end of this section, 4 pages back. .**

The Kansas Money Follows the Person demonstration project "Community Choice" is under the administration of the Kansas Department of Social and Rehabilitation Services, Division of Disability & Behavioral Health Services/Community Supports and Services. The Project Director, Angie Reinking, fills a 100% dedicated FTE under the direct supervision of the Assistant Director. The Project Director's resume has been submitted to the Center for Medicare and Medicaid Services. The Kansas MFP Project Director is responsible for the recruitment and continued coordination of

stakeholder input at all levels. Kansas has committed to a minimum 51% direct consumer membership and involvement in all the task teams and steering committee. Successful project direction includes the coordination and organization across multi-state agencies, development of partnerships (public and private, provider and stakeholder), data collection, training, and outreach activities.

The Kansas Money Follows the Person Project Director is responsible to maintain effective communications with the State Medicaid Director’s staff within the Kansas Health Policy Authority. In addition to SRS actions the Kansas Department of Aging has employed a part-time Transitions Liaison who serves a critical role in the MFP development and implementation. This individual serves as a critical link between SRS and KDOA and the MFP project with stakeholders in the Long-Term Care system that serves Kansans utilizing services for the elderly.

b. The number and title of dedicated positions paid for by the grant. Please indicate the key staff assigned to the grant.

Dedicated Positions			
#	Title	FTE	Key Role / Responsibility
1	MFP Project Director (SRS)	100%	Directs the MFP Project. Plans, organizes, and directs the implementation of Kansas Community Choice (MFP Project)
1	Community Transitions Director (KDOA)	100%	Coordinates between KDOA and SRS and facilitates MFP project actions between MFP – KDOA – consumers – stakeholders – providers – institutional settings and families.
1	MFP Program Consultant (SRS)	100%	Payment systems and fiscal reporting, data tracking

b. Percentage of time each individual/position is dedicated to the grant.

Provided in chart above

c. Brief description of role/responsibilities of each position.

Provided in chart above

d. Identify any positions providing in-kind support to the grant.

Provided in chart below

Positions Providing In-Kind Support			
#	Title	FTE	Key Role / Responsibility
1	Assistant Director, SRS, DBHS, CSS	.10	Supervise Project Director, provide Agency leadership and direction, assess project and staff performance evaluate benchmark outcomes. Supervise the program managers for the disability HCBS waivers, the QA and PI programs

1	Program Manager, Performance Improvement, SRS, DBHS, CSS	.10	Manage the statewide, cross disability Long-Term Care Service Delivery - Performance Improvement program that provides data tracking, trending, compilation, communication, "Community Choice Reflection Team" establishment, direction, leadership. Provides program management oversight for 12 Performance Improvement state staff persons out-stationed across the state of Kansas
1	Program Manager, Quality Assurance, SRS, DBHS, CSS	.10	Manage the statewide, cross disability Long-Term Care quality assurance system. Manages the licensing and minimum assurance standards for MR/DD community service providers. Manages the minimum assurance standards and quality survey process for all HCBS Waivers managed / operated by SRS.
1	Program Manager, MR/DD HCBS WAIVER, SRS, DBHS, CSS	.10	Manage the Mental Retardation / Developmental Disability HCBS Waiver program
1	Program Manager, HCBS PD WAIVER, SRS, DBHS, CSS	.10	Manage the Physical Disability HCBS Waiver program
1	Program Manager, HCBS TBI WAIVER, SRS, DBHS, CSS	.10	Manage the Traumatic Brain Injury HCBS Waiver program
1	Program Manager, ICF/MR, SRS, DBHS, CSS	.25	Manage the Intermediate Care Facilities Program; work with ICFs/MR who are making the choice to voluntarily close certified beds
1	Program Manager, HCBS FE WAIVER, KDOA	.10	Manage the Frail and Elderly (FE) HCBS waiver program
1	Level I or II POC Approver, KDOA	.10	Authorization of POC
12	Quality Assurance Regional staff, SRS	.10	Conduct Quality Assurance monitoring activities statewide
12	Performance Improvement staff, SRS	.10	Facilitate capacity building, community stakeholder information / sharing, best practices on a statewide bases

e. Number of contracted individuals supporting the grant.

There are no contracted individuals directly supporting the management or implementation of the Money Follows the Person demonstration grant.

Existing and new HCBS and state plan service providers will offer all Money Follows the Person services, including targeted case management. This will include not-for-profit, for profit existing and newly created service provider agencies, as well as all willing and capable providers for the individuals who chose to self-direct their qualified services. Demonstration & supplemental services will also be provided by the existing provider network. Individuals who provide transition coordination service (TCS) must meet the same provider requirements as targeted case managers. In addition transition coordinators and case managers will be required to attend an MFP training provided by

state MFP program staff. The Transition coordination service and all other supplemental or demonstration service are included in Quality Assurance reviews of provider agencies.

f. Provide a detailed staffing timeline.

August 13, 2007 - forward: All state agency leadership, project management and HCBS program management staff were in place

As Needed: Capacity will be developed on an individual by individual basis that will ensure that each person as they move from qualified institutional setting into the community setting will have direct care staff in place on day one.

g. Provide in time line format a brief description of staff that have been hired and staff that still need to be hired.

August 13, 2007: MFP Project Director began 100% FTE (SRS)

December 2007: Transitions Director began 100% FTE (KDOA)

To Be Hired – July 1, 2008: MFP Program Consultant

h. Specify the entity that is responsible for the assessment of performance of the staff involved in the demonstration.

SRS/DBHS/CSS staff – Frank Stahl, Assistant Director is responsible for the supervision and performance assessment for all staff working directly with the management, implementation and operation of the MFP project.

KDOA staff person – Bill McDaniel, Commissioner for Program and Policy is responsible for the supervision and performance assessment for all staff working directly with the coordination and as a liaison for the MFP project.

Project Director Resume

Money Follows the Person Project Director

Angela Reinking

PROFESSIONAL EXPERIENCE

Money Follows the Person Project Director

Kansas Social and Rehabilitative Services (SRS), Division of Disability and Behavioral Health, Community Supports and Services, August 2007

Independent Living Counselor- Physical Disabilities Waiver Program

Independence Incorporated, Lawrence, Ks March 2006- August 2007

Support individuals with disabilities to live independently in the community of their choosing

Support people with disabilities in hiring & managing personal attendants

Perform functional assessment to determine eligibility for HCBS PD Waiver program

Provide counseling/case management for individuals receiving services on the PD Waiver program

Maintain accurate & detailed electronic and paper records as required by Medicaid

Advocacy Coordinator

Self Advocate Coalition of Kansas (SACK), 2003- 2006

Provide support & training to SACK self advocate staff

Coordinate trainings on self /systems advocacy across Kansas

Support the continuation & expansion of self advocacy groups across the state

Coordinate annual SACK/self advocacy conference

Program management, grant reports

Conducted pilot study of consumer directed Quality Assurance model

Participation in workgroups: Real Choices Steering Committee, Self Determination Task Force,

Big Tent Coalition, Kansans Mobilizing for Direct Support Workforce Change

AmeriCorps Program Coordinator

Kansas Association for the Medically Underserved (KAMU), Topeka, Ks August 2002- August 2003

Develop & implement Kansas Community Health Corps program

Establish relationships with interested host sites and local supervisors

Recruit AmeriCorps members to do outreach at Kansas Community Health Centers

Support, train, & supervise AmeriCorps members

Prepare/submit online grant reports

Welfare Project Coordinator

Kansas Coalition Against Sexual & Domestic Violence (KCSDV), August 2001 August 2000

Technical assistance and program coordination for statewide welfare advocacy project

Training development, coordination, and delivery for welfare (TANF) workers

OARS program implementation to new target communities

Training/support for advocates who work in welfare offices across state

Legislative advocacy on domestic & sexual violence/welfare/poverty/ issues at state level

Developmental Disabilities Resource Center Coordinator

Metropolitan Organization to Counter Sexual Assault (MOCSA), Kansas City, Mo

May 2001-August 2001

Program coordination

Crisis intervention for sexual assault survivors with disabilities

Grant writing /grants management
Outreach & community education, one-on-one education on sexuality & safety
Train service providers on the sexual rights of individuals with developmental disabilities

Independent Living Skills Trainer/ Rural Outreach

Independence Inc., Lawrence, Ks, June 1999-April 2001

Consumer directed skill enhancement; budgeting, cooking & organization
Encourage/foster self advocacy skills
Outreach in Franklin & Jefferson counties to increase awareness of services
Create & foster connections with agencies/individuals in rural communities
Document service delivery

Teaching Counselor

Community Living Opportunities (CLO), Lawrence, Ks, 1994-1999

Rural Outreach Coordinator

Women's Transitional Care Services (WTCS), Lawrence, Ks, November 1997-December 1998

Outreach in Jefferson and rural Douglas County
Peer counseling with survivors of domestic violence
Grant writing and fundraising
Volunteer training delivery

Personal Care Attendant

Julie Steward, Lawrence, Ks, March 1993-1997

House Manager

Women's Transitional Care Services, Lawrence, Ks, August 1993-July 1994

Coordinate operations of 24-hour shelter for woman and children escaping domestic violence
Volunteer training design and delivery
Peer counseling, crisis intervention.

House Manager/Teacher

Draco Residences, Austin, Tx, June 1992-Oct 1992

Case Manager/Teaching Counselor

Community Living Opportunities, Lawrence, Ks, 1990-June 1992

EDUCATION

Bachelor of Science, Organizational Management and Leadership: **Friends University** 2000
Master's of Social Welfare, Administration & Advocacy Practice: **University of Kansas** May 2007

VOLUNTEER EXPERIENCE

Program Volunteer *UMKC Venezuela Dental Outreach Trips* (March & April 2005)
Women's Advocate *Women's Transitional Care Services* (1990-2000)
Board of Directors *Women's Transitional Care Services* (Oct 1990-June 1992) (1999-2001)
Victim Advocate *Douglas County District Court* (1997-2000)

Part D - Evaluation

Although not required as a component of the MFP demonstration, States may propose to evaluate unique design elements from their proposed MFP program. If these activities are undertaken by the State, the following information must be provided to CMS:

Kansas is currently developing a plan for an evaluation of the MFP Demonstration. Kansas has met with our Money Follows the Person Steering Committee to determine the specific area of focus for evaluation in Kansas. SRS is now working to develop an evaluation proposal in response to suggestions from our stakeholders. It is anticipated that we will have a complete evaluation plan no later than May 15th, 2008. When this plan is complete we will submit an amendment to this *Operational Protocol*.

Part E - Final Budget

1. MFP Budget Form: Utilizing the MFP Budget Form provided in Appendix C (relocated to Appendix I in the Operational Protocol), include an annual budget divided into the categories described below. The MFP Budget Form is set up to have the states fill in necessary information and then CMS can use the information to automatically calculate several indicators. The only cells that should be filled in by the States are those highlighted in yellow. Most of these cells represent total cost measures. This means that the number filled in should be the total costs of the service or administrative expense (not just the enhanced portion and not just the state or federal share).

Please see **Appendix F** for the MFP Demonstration Final budget-state format, & **Appendix G**, SF 424 format.

a. Enrollees: An unduplicated count of individuals the State proposes to transition under the demonstration. Please count the person in the year that he or she will physically transition.

Kansas proposes to transition 963 individuals during this demonstration project. This information is on the MFP Budget form located in Appendix F. It is also detailed in the services chart, Appendix C.

b. Services: In each service costs section, provide cost estimates for the maximum number of participants in the demonstration project and their projected annual service costs.

i. “Qualified home and community-based program” services (eligible for enhanced FMAP);

ii. Home and community-based demonstration services (eligible for enhanced FMAP); and

iii. Supplemental demonstration services (those eligible for the regular FMAP).

This information is on the MFP Budget form located in Appendix F.

c. Administrative Budget: Please include projections for annual costs regarding the routine administration and monitoring activities directly related to the provision of services and benefits under the demonstration. Indicate any additional actions that are required to secure State funding (e.g., appropriation by the legislature, etc.), as well as costs associated with participation with the National Evaluation and Quality initiatives implemented by CMS.

This information on the MFP Budget form located in **Appendix F**.

d. Evaluation Budget:

2. Budget Presentation and Narrative: Please provide a budget presentation and narrative that provides justification for items E.1.c. and E.1.d. above. Please address the following items:

a. Personnel

3 full time employees (FTE), including MFP Project Director.

b. Fringe benefits

Standard benefit package for 3 FTE.

c. Contractual costs, including consultant contracts

For state evaluation; also contract for database design and maintenance.

d. Indirect Charges, by federal regulation

As listed in budget.

e. Travel

Out of state travel to attend required MFP Demonstration related meetings and in-state travel to attend meetings to discuss, promote, and educate people and organizations about the MFP Demonstration, including representatives from public housing authorities.

f. Supplies

General office supplies, etc.

g. Equipment

Computer/software, etc.

h. Other costs

N/A

3. The operational protocol should be submitted with a final budget. Below are links to the required forms to include with the protocol:

- <http://www.whitehouse.gov/omb/grants/sf424.pdf> (Application for Federal Assistance SF-424)
- <http://www.whitehouse.gov/omb/grants/sf424a.pdf> (Budget Information Sheets)
- <http://www.whitehouse.gov/omb/grants/sf424b.pdf> (Assurances-Non Construction SF-424B)
- <http://www.cms.hhs.gov/states/letters/certns.pdf> (Additional Assurances)
- <http://www.whitehouse.gov>

All forms referenced above are being submitted with this Operational Protocol, see **Appendix G**.