

**Money Follows the Person Rebalancing Demonstration**  
**Request for Additional Information - Response**  
*Kansas*

Kansas thanks CMS and the grant review teams for the opportunity to provide additional information and clarifications to our Money Follows the Person Rebalancing Demonstration.

**Section I. Verification of Budget**

{Request}

To clarify information that was interpreted differently across States, we are asking all States to complete the attached excel file titled MFPBudgetForm.xls. This file is set up to have the states fill in necessary information and then use the information to autocalculate several measures. 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.)

{Kansas Response}

Attachment: MFPBudgetForm.xls

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**Section II. Rebalancing Benchmarks**

Two specific benchmarks were required by all applicants in their responses to the RFP. These two benchmarks were:

- 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.
- Qualified expenditures for HCB services during each year of the demonstration program.

Most States clearly met this requirement and any lack of clarity will be resolved because the information necessary for these two benchmarks is reinforced on the budget form discussed in the previous section.

In addition to the benchmarks on the transition program, states were asked to discuss the rebalancing objective of the demonstration and provide proposed annual benchmarks establishing empirical measures to assess the State's progress in rebalancing its long-term care system. In approved applications, these proposed measures will be further developed and approved as part of the approval process for the Operational Protocol. However, in many applications identification of the rebalancing goals of the States was difficult.

{Request}

For purposes of responding to this Request for Additional Information, the State must submit a response to the first bullet from the operational protocol excerpt above: “A percentage increase in HCB versus institutional long-term care expenditures under Medicaid for each year of the demonstration program”. The State should list the years of participation and the percentages of HCBS versus institutional spending.

Additionally, the State must discuss in narrative form what changes it intends to make over the duration of the demonstration that will establish lasting improvements enabling money to follow the individual. The State may use the suggestions above from the operational protocol or it may propose others. This response should be no more than two pages.

*{Kansas Response}*

*Response contained on page 3 and 4 of this document: (2 page limit)*

## **Rebalancing Benchmarks**

### **Trusted, visible, reliable system for accessing information and services**

Kansas has three strong well defined and highly agile organizations that are partners with the Kansas Department on Aging and the Kansas Department of Social and Rehabilitation Service systems. 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 which act as gatekeepers for the Physical Disability (PD) and Traumatic Brain Injury (TBI) systems, and Area Agencies on Aging (AAAs) which are the single point of entry 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 to develop a "no wrong door" approach to accessing services, spanning all ages and all disability types.

### **Community Workforce**

SRS and KDOA will develop a consortium of agencies, departments, private resources and advocates to identify education, training, support, pay and benefits that are needed to assure individuals with disabilities have ready access to support staff that will be trained to meet the individual needs of the person with disabilities. The consortium will advocate and make recommendations for funding that implements career track opportunities including salary structure and benefits that provide incentives for long term professional employment.

Through this demonstration the state will develop continuing strategies to promote the image of direct care staff, will provide funding for the College of Direct Supports, will promote the use of the K-PASS Self-Direction Tool Kit, and will provide funding for specific training for working effectively with people from a variety of backgrounds and disability conditions and experiences. The Supplemental Services identified in the MFP demonstration grant focus a large portion of the dollars on the development of a well trained and supported work force.

Kansas is the recipient of a 2006 Real Choice Systems Transformation grant. This project focuses heavily on funding of the LTC system; assessing the funding structure, identifying the true costs to serve, and ensuring available trained care givers are compensated appropriately. Implementation of the Systems Transformation grant and the resulting recommendations will positively impact the availability and quality of service providers.

### **Transition coordinators**

The state plans to move Independent Living Counseling out of the HCBS PD Waiver and into a state plan Targeted Case Management service. Qualified staff will serve as Targeted Case Managers in each of the target population fields and will provide transition counseling services. The change from Independent Living Counseling to a Targeted Case Management Service will

create a permanent and continuing core of transition counseling staff. This enhancement will give Kansas the ability to provide transition coordination from institutional services, both during this grant demonstration period and as a permanent part of the LTC system in Kansas. The transition coordination process is an identified part of the Kansas LTC structure across all disabilities and is currently achieved through a Kansas Legislative Proviso between the Kansas Department on Aging and the Kansas Department of Social and Rehabilitation Services through the statewide implementation of the Kansas MFP protocol that authorized budget transfer of institutional costs into the community services programs for up to 80 persons annually. The MFP demonstration grant expands this opportunity and Kansas will work to make statutory changes to ensure that the provisions of the MFP demonstration project have long ranging impact beyond the demonstration period.

Overall assessment:

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 proposal, 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.

MFP will open institutional doors to Kansans who desire to return to the community. Kansas will utilize the innovative demonstration services proposed to develop “prevention” services to be considered as permanent waiver services 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.

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 converted into a flexible financing tool that will assure that any Kansan who is institutionalized can utilize his or her institutional service funding to return to the community, without having to be on waiting lists for funding or available services.

The Systems Transformation grant provides Kansas the opportunity to conduct an in-depth analysis of our current system to determine the true needs of Kansans that will enable them to live independent, productive and self directed lives.

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### **Section III. Issues Raised through Independent Review**

States receiving this request for additional information were states that received reduced scores because independent reviewers, expert in the field of long-term care, raised significant issues to CMS in the review process. CMS staff has subsequently performed an analysis of the issues raised, and have generated a list of questions to be addressed by the State and included in the State's response. The response to these questions may be as long as necessary to clearly address the question.

State Specific questions:

{Request}

1. The State's application focuses primarily on individuals with mental retardation and/or developmental disabilities. However, the state proposes to transition significant numbers of individuals who have physical disabilities and/or are elderly. Please provide more detailed information regarding the services currently available in the State, as well as those proposed under the demonstration, for each population proposed to be transitioned under the demonstration. In addition, please provide more detailed information about the current home and community-based waivers serving each of the proposed demonstration populations.

*{Kansas Response}*

#### **Current Transition Services for PD Waiver Consumers**

A network of Centers for Independent Living and community service providers have supported people of all ages and with all types, natures and severities of disabilities in transitioning from institutions into the community for many years in Kansas. This network of individual organizations provides a comprehensive array of advocacy, supports and services.

Services that may be provided by Centers for Independent Living in supporting consumers' transitions into the community are:

- Housing
- Deposit Assistance
- Home Modifications and Accessibility Modifications
- Utility Assistance
- Utility Coordination
- Medical services coordination
- Pharmaceutical coordination
- In-home therapies coordination
- Durable Medical Equipment assistance
- Medications management
- Household goods
- Social Service providers for household goods donations
- Moving Assistance
- Establishing eligibility for in-home long-term-care supports
- Help coordinating in-home long-term-care supports
- Management of in-home supports
- Set up and management of a household budget

- Personal Emergency Response System coordination
- Transportation coordination and assistance
- Payee assistance
- Benefits assistance

In addition to the “five core” services provided by Centers for Independent Living, many Kansas Centers have diversified the services they provide to ensure that essential services are available in Kansas communities. Several Centers for Independent Living are service providers for the Kansas Accessibility Modification Program (KAMP) which makes housing trust funds available for low-income households to make needed accessibility modifications to homes. Other Centers for Independent Living are assistive technology centers offering durable medical equipment and other supports for using technology to promote independence. Centers for Independent Living offer “donation centers,” where donated household goods ranging from couches to curtains are available free of charge to consumers who are establishing households.

### **Benefits of the Demonstration Enhancements to Transition Services**

Centers for Independent Living, Home Health Agencies (affiliated to provide independent living counseling) and other community service providers will expand upon their existing structures to develop individually appropriate community services and resources well in advance of the consumer’s anticipated move date. This will ensure that services are available the day of exit from the nursing facility. Once consumers have been connected to a Center for Independent Living or Home Health Agency, the two largest impediments for offering true choice in living arrangements are time and money.

Kansas’ proposal addresses both transition services prior to discharge and “start up” / transition services. Kansas’ state plan for TCM provides for a 180-day prior to discharge transition service to ensure that all necessary supports are available and resources have been coordinated when before the individual moves back into the community. Without “start up” funding consumer choice is greatly impeded by the lack of resources. With only \$30 - \$50 a month available for any type of discretionary expenses, people who live in nursing homes cannot afford to pay deposits, acquire needed medical equipment, or use public transportation to explore their community. Transition funds will provide flexibility and true choice for people whose options have previously been limited by lack of financial resources.

### **Information about the HCBS Physical Disability (PD) Waiver Program**

Currently, Independent Living Counseling under the Home and Community Based Services Physical Disabilities (HCBS PD) Waiver is limited in its scope of reimbursable services to the month when the consumer’s services start, which for people moving from institutions to the community, is the date of the actual physical move from an institution. Within this month timeframe, Independent Living Counselors do their best to assist consumers with establishing all needed community supports, in-home attendant services, and any other independent living skills training necessary to promote the consumer’s health, safety, well-being and freedom.

In addition to Independent Living Counseling, the services available to consumers through the HCBS PD Waiver include:

- Personal assistant services
- Sleep cycle support services
- Personal emergency response services
- Non-emergency medical transportation services
- In-home meal delivery services; and
- Health maintenance activities support.

PD Waiver consumers may choose to “self-direct” (co-employer) their services, selecting, dismissing and managing their own in-home workers who are paid through a fiscal intermediary. Alternatively, consumers may choose to have an agency direct their care, including selecting and sending support workers to the consumer’s home. Consumer choice is documented in writing through a signed and dated form that is kept in individual, confidential consumer service files. PD Waiver services are available to people with physical disabilities who meet a level of care need score equivalent to the minimum score required to establish eligibility for nursing facility care. The amount, intensity and level of services available to individuals are based on presenting need, functional ability and services chosen by the consumer.

**Current services available to senior consumers:**

Kansas offers support for an array of community based services for seniors. Utilizing a “single point of entry” Targeted Case Management system, the Kansas Area Agencies on Aging are responsible for coordinating home and community based services through a network of direct service providers. Community based services available include, but are not limited to:

- Information, assistance and referral
- Homemaker services
- Chore services
- Nutrition services
- Respite care
- Caregiver support to family members, including grandparents
- Transportation coordination and assistance
- Housing options
- Medicare education and counseling
- Durable Medical Equipment assistance
- Utility assistance and coordination
- Access to donated household goods
- Access to home modification programs

Under the Medicaid Home and Community Based Services/Frail Elderly (HCBS/FE) Waiver, seniors may choose to “self-direct” their services by selecting, dismissing and managing their own in-home workers who are paid through a payroll agent. Customer choice is documented in writing through a signed and dated form that is kept in an individual, confidential customer service file. HCBS/FE waiver services are available to seniors who meet a level of care need

score equivalent to the minimum score required to establish eligibility for nursing facility care. Services specific to Medicaid HCBS/FE Waiver include:

- Adult day care
- Assistive technology
- Attendant care
- Medication reminder
- Nursing evaluation
- Personal emergency response equipment
- Sleep cycle support
- Wellness monitoring.

The single point of entry system for seniors is the result of a major Legislative initiative that became effective in January of 1997. Since implementation in 1997, Kansas has experienced a reduction in the number of Medicaid certified nursing facilities and nursing facility beds. In 1998, there were 368 Medicaid certified nursing facilities compared to 331 in 2006. In 1998, the number of Medicaid certified beds was 25,261 compared to 22,234 in 2006. Even with the reduction in the number of Medicaid certified nursing facilities and nursing facility beds, Kansas continues to see occupancy levels of less than 85%. In other words, the demand for nursing facilities and nursing facility beds continues to decrease year after year. Seniors in Kansas, when given the choice, are choosing community based services as opposed to nursing facility care.

Included with this narrative is a spreadsheet showing the change in demand for Medicaid services. Since 1997, nursing facility caseload has gradually declined. Considering the demographics, with 13.3% of Kansas' population over the age of 65, this decrease in Medicaid nursing facility caseload reflects a change in seniors' behavior. Conversely, the Home and Community Based Services/Frail Elderly Waiver program continues to experience an increase in caseload with the exception of 2003 and 2004 when a waiting list was implemented due to budget constraints. The attached charts capture the cost effectiveness of the HCBS/FE waiver program, in addition to the 372 report data submitted earlier.

During the summer of 2006, in response to a Legislative Medicaid Reform Committee Report, the Secretary of the Kansas Department on Aging convened a work group to discuss options to enhance current long-term care systems in Kansas. The work group was comprised of consumers, advocates, trade associations representing nursing facilities, home health, Centers for Independent Living, Area Agencies on Aging, researchers, and staff from three state agencies. The preamble, purpose and desired outcome were as follows: 1) Preamble – The State of Kansas adopts a philosophical commitment and a legislative directive to ensure funding of long-term care services in the individual's environment of choice. 2) Purpose - To determine, based upon data, the systems changes needed to improve diversion and discharge from nursing facilities. 3) Outcome – To enhance customer choice. Key enhancements related to transition activities include:

1. Provide consumers and family members with immediate access to information about long-term care options, from community services to the extensive services provided in a NF. Promote a statewide 1-800 HELP line operating 24 hrs/day, 7 days / week for caregivers and family members to inquire about community services and resources available locally. The system will route individuals to specific regions. The HELP

operator could interview persons to determine the level of care needed and which programs the individual may be eligible for. In addition, Kansas will promote web-based information to include calculators to provide similar information.

2. Build counseling and informal support networks. Utilize case managers, counselors and/or others who can help the individual maintain and build peer and other supports that will support plans for community life.
3. Use data to identify individuals who desire to be discharged back to the community using orderly process, which will include:
  - a. Upon admission, and throughout the stay, the person indicates a desire to return to community (making this consumer driven and both CARE assessment and MDS have this question recorded); Affirmative responses indicating a desire to return to the community will invoke the following system:
  - b. Generate a list using both screenings and either tool with a positive response will be used to generate list;
  - c. Share list with AAA or CIL and NF within a specified time frame, and notify the NF resident or his/her legal representative that the resident is a candidate for discharge;
  - d. CM/ILC, NF, and the NF resident or legal representative conference within specified time frame;
    - i. NF shares additional factors that relate to discharge potential;
    - ii. NF shares internally-developed discharge plan;
    - iii. CM/ILC provides information and technical assessment as needed; and
    - iv. Dialogue, possible consensus building on discharge potential; and
    - v. AAA/CIL makes contact with individual regarding discharge potential and next steps.
4. Increase asset disregard used in calculating financial eligibility for Medicaid. As a result, consumers can retain assets to pay for home maintenance and accessible home modifications.

**Information about the HCBS/FE Waiver Program**

The foundation of the HCBS/FE Waiver is the philosophy that services are provided to individuals in community settings, as needed, regardless of housing choice. The following chart provides ten years of HCBS/FE Waiver information regarding caseload and expenditures for fiscal years 1998 through 2008 projections:

Average Caseload	Percent Change	Annual Expenditures	Avg. Monthly Cost	Percent Change
1998 3,332		\$26,884,055	\$672	
1999 4,284	28.6%	35,898,475	698	3.86%
2000 4,877	13.8%	43,707,935	747	6.95%
2001 5,237	7.4%	49,585,203	789	5.65%
2002 5,697	8.8%	57,459,600	840	6.52%
2003 5,139	-9.8%	53,474,142	867	3.17%
2004 4,548	-11.5%	45,076,565	826	-4.75%
2005 5,544	21.9%	53,877,188	810	-1.95%
2006 5,820	5.0%	57,562,192	824	1.77%
2007 projection 5,921	1.7%	63,541,152	894	8.50%
2008 projection 6,013	1.6%	65,447,389	906	1.31%

Services Kansas proposes for all population groups under the MFP Demonstration Project include:

	2007 (Jan-Sept)	2008	2009	2010	2011
Populations to be transitioned	Individuals with physical disabilities that are residing in Nursing Facilities (NF) and would like to move to a community setting with HCB Services.				
	Individuals traumatic brain injuries that are residing in Nursing Facilities (NF) and would like to move to a community setting with HCB Services.				
	Individuals that are 65 + that are residing in Nursing Facilities (NF) and would like to move to a community setting with HCB Services.				
	Individuals with mental retardation / developmental disability that are residing in a Intermediate Care Facility (ICF/MR – private) and would like to move to a community setting with HCB Service				
	Individuals with mental retardation / developmental disability that are residing in a Intermediate Care Facility (ICF/MR – SMRH) and would like to move to a community setting with HCB Service				

Estimated number of individuals to be transitioned	2007 (Jan-Sept)	2008	2009	2010	2011
PD		121	78	78	79
TBI		20	10	10	10
Elderly		92	50	50	50
MR/DD private ICFs/MR		28	45	59	59
MR/DD [SMRH] ICFs/MR		5	10	30	50
Geographic Areas to be covered	Statewide				
Qualified Institutional Settings:	Nursing Facilities				
Qualified Institutional Settings:	Intermediate Care Facilities for the Mentally Retarded (private)				
Qualified Institutional Settings:	Intermediate Care Facilities for the Mentally Retarded (State Mental Retardation Hospitals [SMRH])				
Qualified Community Settings:  PD Elderly TBI	- individuals residence of choice: <ul style="list-style-type: none"> <li>▪ A home owned or leased by the individual or the individual's family member</li> <li>▪ An apartment with an individuals lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control;</li> </ul>				
Qualified Community Settings:  MR/DD	- individuals residence of choice: <ul style="list-style-type: none"> <li>▪ A home owned or leased by the individual or the individual's family member</li> <li>▪ An apartment with an individuals lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control;</li> <li>▪ A residence, in a community-based setting, in which no more than 4 unrelated individuals reside</li> </ul>				
PD	FE	TBI	MR/DD	MR/DD Special population	Demonstration Services
x	x	x	x	x	Amendment to Waivers to include "Transition Service" to enable Kansas to assist individuals to establish community homes upon exiting a qualified institutional setting
x	x	x	x	x	Exceed limitations (financial or qualified setting) that may exist in currently approved waiver for home modifications specifically making home health, safety & mobility a priority. Payment for items for which a determination has been made that it will assist to ensure successful community living.
	x	x	x	x	Exceed limitations (financial, qualifying requirements, medical orders) that may exist in currently approved waivers for assistive technology devices, adaptive equipment & supplies for items for which a determination has been made that it will assist to ensure successful community living.
PD	FE	TBI	MR/DD Exiting Private ICFs/MR	MR/DD Special populations Exiting State MR Hospitals	Supplemental Services

x	x	x	x	x	Build community bridge building / prevention activities and supports that are focused on developing / expanding the local community capacity to provide effective supports. The focus is on generic community services that are or available to all Kansans and assuring access by aging and disabled. Living successfully in the community means being a meaningful part of the community.
x	x	x	x	x	Build a competent successful community workforce by assuring staff are trained / certified to provide the level and intensity of supports each individual staff needs to ensure effective supports and services. Focus is on assisting direct care staff to build their individual skill levels thereby ensuring that the persons transitioned into the community have a greater opportunity to receive effective services in their home community residences thereby eliminating the need for long term institutional care.
		x	x	x	Therapeutic support [technology needed to ensure community integration success] specific focus on equipment, technology or services that provides assistance for community integration for individuals with aggressive and/or offender behaviors, past criminal acts, and brain injuries that require therapeutic support or technology that is not provided through waiver services or extended SPA benefits.
x	x	x	x	x	Prevention - Support Team development. Successful community living requires love, nurture and support beyond that of dedicated professionals and direct care staff. It includes families, friends and acquaintances. Individuals residing in and returning from institutional settings have often times outlived, moved beyond, worn out and/or have been abandoned by those who would typically been a natural support structure. The activity would fund the development / training of members in the persons community to and support required to build an effective support team [team that is specific to that person and the issues that accompany them into the community]

Qualified HCB Services:				
Elderly	MR/DD Special Population Exiting Private Operated ICF/MR	MR/DD Special Population Exiting State Operated ICF/MR	Physical Disability PD	Traumatic Brain Injury TBI
Adult Day Care	Personal Assistant Services (amendment pending)	Personal Assistant Services (amendment pending)	Personal Services	Assistive Services

Assistive Technology	Residential Supports	Residential Supports	Assistive Services	Behavior Therapy
Attendant Care Services	Respite Care	Respite Care	Oral Health Services (amendment pending)	Cognitive Rehabilitation
Personal Emergency Response, Install, and Rental	Supported Employment	Supported Employment	Personal Emergency Response System	Drug & Alcohol Therapy
Medication Reminder Services	Supportive Home Care	Supportive Home Care	Personal emergency Response Install	Occupational Therapy
Nurse Evaluation Visit	Wellness Monitoring	Wellness Monitoring	Sleep Cycle Support	Oral Health
Sleep Cycle Support	Assistive Services	Assistive Services	Transition Service (start up costs)	Personal Emergency Response System
Wellness Monitoring	Day Supports	Day Supports	Personal Services	Personal Emergency Response Installation
	Family Individual Supports	Family Individual Supports	Assistive Services	Personal Services
	Medical Alert Rental	Medical Alert Rental	Oral Health Services	Physical Therapy
	Sleep Cycle Support	Sleep Cycle Support	Personal Emergency Response System	Sleep Cycle Support
	Overnight Respite Care	Overnight Respite Care	Personal emergency Response Install	Speech and Language Therapy
	Oral Health	Oral Health	Sleep Cycle Support	Transitional Living Skills

Demonstration HCB Services:				
Elderly	MR/DD Special Population Exiting Private Operated ICF/MR	MR/DD Special Population Exiting State Operated ICF/MR	Physical Disability PD	Traumatic Brain Injury TBI
1. Transition Service (start up costs)	1. Transition Service (start up costs)	1. Transition Service (start up costs)	1. Transition Service (start up costs)	1. Transition Service (start up costs)
2. Home Modifications to ensure health	2. Home Modifications to ensure health safety and mobility	2. Home Modifications to ensure health safety and mobility costs that	2. Home Modifications to ensure health	2. Home Modifications to ensure health

safety and mobility costs that exceed current Waiver limitations	costs that exceed current Waiver limitations	exceed current Waiver limitations	safety and mobility costs that exceed current Waiver limitations	safety and mobility costs that exceed current Waiver limitations
	3. Adaptive equipment / supplies including items not covered by a similar waiver service	3. Adaptive equipment / supplies including items not covered by a similar waiver service	3. Adaptive equipment / supplies including items not covered by a similar waiver service	3. Adaptive equipment / supplies including items not covered by a similar waiver service

Supplemental HCB Services:				
Elderly	MR/DD Special Population Exiting Private Operated ICF/MR	MR/DD Special Population Exiting State Operated ICF/MR	Physical Disability PD	Traumatic Brain Injury TBI
	1. Therapeutic support; including necessary technology to assure long term community integration and support.	1. Therapeutic support; including necessary technology to assure long term community integration and support.		1. Therapeutic support; including necessary technology to assure long term community integration and support.
2. Community Bridge Building – (capacity building) the expansion of systems, supports and structures that will assure this person and others in the future have access to generic, community inclusive services.	2. Community Bridge Building – (capacity building) the expansion of systems, supports and structures that will assure this person and others in the future have access to generic, community inclusive services.	2. Community Bridge Building – (capacity building) the expansion of systems, supports and structures that will assure this person and others in the future have access to generic, community inclusive services.	2. Community Bridge Building – (capacity building) the expansion of systems, supports and structures that will assure this person and others in the future have access to generic, community inclusive services.	2. Community Bridge Building – (capacity building) the expansion of systems, supports and structures that will assure this person and others in the future have access to generic, community inclusive services.
	3. Staff training (certification) specific to the needs of the person leaving the institutional setting	3. Staff training (certification) specific to the needs of the person leaving the institutional setting		3. Staff training (certification) specific to the needs of the person leaving the institutional setting
	4. Licensed facility bed			

	buyback - these beds would be permanently closed and the operator would not be allowed to add capacity.			
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Some specifically identified high points of the Kansas LTC community services system include:

**Screening, identifying, and assessing persons who are candidates for transitioning to the community**

Kansas statute requires that all individuals receiving ICF/MR services and their families are to be provided information regarding home and community based service options. This demonstration will offer additional resources to provide incentives to close ICF/MR beds and assist those consumers who have chosen to receive institutional services to feel adequately supported to receive services in the community.

KDOA will pilot a process to share MDS information so case management and transition services can be offered to nursing facility residents who wish to return to the community.

Additionally, an eligibility assessment tool will be developed during the pre-implementation phase of the demonstration to be utilized while working with each identified person who is currently in or enters the institutional setting and has indicated a desire to return to his or her home community. The assessment instrument will include the following key components:

- Person meets 6 month (continuous) institutional residency
- Person has been eligible for Medicaid for at least 30 days
- Need for community supports have been identified
- Eligibility for HCBS services has been determined / documented
- DME and/or home modifications required for successful move to community has been determined – plan developed
- Risk Mitigation Assessment completed

**Flexible financing strategies**

Gaps in the current system have been identified and will be addressed during the demonstration, including funding for transition services for Waiver consumers and funding for creation of individualized programming to allow an individual to successfully remain in the community.

In addition to this demonstration, SRS is a recipient of a 2006 Real Choice Systems Transformation grant. A primary goal of that project is “Creation of a system that more effectively manages the funding for long-term supports that promote community living options.” This goal will be accomplished by development and implementation of a more effective payment methodology. Emphasis will be placed on addressing geographic, health and financial obstacles to meeting individual needs in home communities.

The MFP Demonstration Project will provide Kansas the opportunity to expand community based services through the funding of the MFP Benchmarks beyond the demonstration period. The MFP gives the “startup” funding necessary to develop the system capacity, funding

flexibility, and professionally trained workforce that is necessary to increase community services, particularly for individuals that bring challenging needs into our communities.

### **Available and accessible supportive services**

Funding that provides for these services and for home modifications, adaptive equipment, and funding will be available to demonstration participants, as additional services that exceed the established financial or quantity limitations as established in the current waivers. Through implementation of this demonstration in conjunction with the Systems Transformation project, the capacity within the entire system will be increased to ensure available and accessible supports for both current and future consumers. The Demonstration and Supplemental Services of the MFP Demonstration Grant expand current capacity and ensure participant success.

### **Increasing self-directed services**

Although the state of Kansas already has a strong self-directed service delivery model in place, another primary goal of the Real Choice Systems Transformation grant is “Increased choice and control: enhancement of self-directed service delivery system.” The Systems Transformation grant aims to make broad infrastructure changes which will impact Medicaid eligible individuals beyond those participating in the Money Follows the Person demonstration. Through implementation of this goal, the state plans to develop or enhance person centered planning, individualized budgeting, and participant-employer options. The anticipated outcomes will be the increased /improved opportunity for persons making the choice to self-direct services regardless of the specific disability services they access.

### **Health information technology**

Transformation of Information Technology is the third primary goal of the Systems Transformation grant. With the resources provided by the grant, the state intends to design IT applications that will support program practices and processes that are individual-centered and enable persons to direct their own services, improve client access to long-term care services through the use of integrated IT systems, and use integrated systems to monitor the quality of services rendered.

### **Improving Cultural and Linguistic Competency**

Because SRS understands that cultural and linguistic competence is imperative for responding to the varied needs of the consumers it serves, the agency has developed a three phase action plan to be implemented throughout 2007 to impact organizational culture resulting in policies and practices that promote diversity, establishment of strategies to accommodate linguistic needs, and ongoing review of program, policy, and financial decisions to assess whether service delivery is representative of communities of diverse populations.

## **Interagency and public/private collaboration**

Interagency collaboration is at an all time high within the state under the leadership of Governor Sebelius and her philosophy that in Kansas we are “one government.” Kansas also has a long history of collaboration with stakeholders. Gathering input, understanding consumer concepts, and maintaining continuous consumer involvement is Kansas’ standard procedure.

For the purpose of this demonstration, the SRS, KDOA, and stakeholders will develop a Money Follows the Person Steering Task Force, identified as “Community Choice”. The Secretary’s of SRS and KDOA will appoint members to the task force to assure that there is a consistent minimum 51% direct long term care consumer / family / guardian representation. Other members of “Community Choice” will include: advocacy organizations across all disabilities; community service providers; provider organizations; and state agencies. Community Choice will monitor the progress of the demonstration project and will submit regular reports containing assessments of progress and recommendations to the Secretaries of SRS and KDOA.

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{Request}

2. As the State’s application focuses primarily on individuals with mental retardation and/or developmental disabilities, key information regarding the transition of elderly individuals is lacking. Demonstration activities, for the elderly population, seem to focus primarily on diversion activities not transition activities as required by the demonstration. Please provide detailed information regarding the transition of elderly individuals into qualified residences.

*{Kansas Response}*

### **Current Transition Services for Seniors**

For the past ten years, the Kansas Department on Aging has focused on developing, implementing, monitoring, and enhancing the availability of long-term care services to Kansas seniors that support choice. Policies, procedures, and best practices are discussed and reviewed with seniors, families, advocates, and stakeholders throughout the year. KDOA has a rich history of piloting system enhancements, researching current activities to promote evidence-based practices, sharing data and information with customers and stakeholders, and implementing changes.

A process KDOA “tested” several years ago was known as the Resident Status Review process. The process captured data from the nursing facility Minimum Data Set (MDS) and provided names of residents of all ages that were candidates for nursing facility discharge to Area Agencies on Aging and Centers for Independent Living. While outcomes of the process suggested early intervention was the key to success for transitioning seniors from nursing facilities, the Money Follows the Person will allow for the transition of the more difficult to transition persons who have been in a nursing facility longer than six months.

A critical component necessary to the success of transitioning senior residents from nursing facilities is establishment of a process for screening, identifying, and assessing persons who are candidates for transitioning to the community. As a rebalancing benchmark, this resubmission includes the development of a process based on nursing facility MDS data, as outlined on the CARE Enhancement report. Due to confidentiality issues, KDOA will submit an addendum to CMS to provide the names of residents in Kansas nursing facilities who indicate on Section Q of the MDS a desire to return to the community, along with other data elements from the MDS, to Area Agencies on Aging and Centers for Independent Living. Kansas currently holds an approved MDS ADA Data Use Agreement.

### **Benefits of the Demonstration Enhancements to Transition Services**

Proposed demonstration services for the HCBS/FE Waiver program would provide funding to ensure all necessary supports are available and resources have been coordinated when an individual moves back to the community. Demonstration services would include, but not be limited to, providing start-up costs, such as paying deposits and purchasing household items, and making home modifications that improve accessibility and safety. In addition, supplemental services will allow for the purchase of one-time adaptive equipment/supplies/training not covered by home modification through Waiver funds.

The coordination of the HCB demonstration and supplemental services for seniors would be the responsibility of the current network of Area Agency on Aging providers, through the single point of entry Targeted Case Management system, ensuring consistency and continuity of care for Kansas seniors.

In conclusion, transition activities into qualified residences for seniors include: the process of identification as noted above utilizing Targeted Case Management, and the coordination and provision of HCB qualified services, HCB demonstration services, and HCB supplemental services.

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**The following items were of concern to the review panel. Although they do not need to be addressed at this time, if your application is awarded, these issues must be addressed in your Operational Protocol, and approved by CMS, before you may proceed with implementation of the demonstration.**

{Request}

1. Please provide more detailed information regarding the procedures for “informed consent” that will be utilized in the demonstration.

*{Kansas Response}*

### **Procedures for ensuring informed consent**

The Kansas Community Choice MFP steering committee will develop a tool for providing informed consent during the pre-implementation period of the grant. 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 counselors responsible for assuring individuals are making informed choices and respecting individual rights. The steering committee will develop a protocol for institutional providers to review informed consent and to allow residents equal access to community resources on a routine basis.

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 confirm a known relationship between the guardian and the individual and document the number of visits between the two in the month prior to transition.

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{Request}

2. Please provide more information as to how consumer satisfaction will be measured during the demonstration.

*{Kansas Response}*

**Customer satisfaction**

The approved Kansas Quality Management Strategy for all currently operated waivers that will be utilized to serve demonstration participants will be enhanced to include a 100 % monitoring of all individuals transitioning out of institutional settings during the first year in the community. This is an enhancement over the current random sampling techniques that are employed. The enhanced monitoring will include specific satisfaction determination outcomes utilizing techniques and a tool that will be developed by the 51% consumer steering committee ("Community Choice") utilizing technical assistance from the MFP Demonstration Project contracted evaluators.

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

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{Request}

3. Please provide more detailed information regarding the collaboration needed with current long-term care providers and with the Centers for Independent Living in the State.

*{Kansas Response}*

**Collaboration between current long-term care providers and Independent Living Centers**

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. The first steps have already been taken as a variety of groups were brought together during the application phase of this project, including Independent Living Centers and long-term care providers. A great diversity of individuals, organizations and agencies will also be brought together in the development of a strategic plan.

A demonstration strategy developed during the application phase is for the state to target all remaining ICFs/MR for voluntary closure through an incentive package design to effectively support the person in the community and assist the organization to convert to community service provision. This strategy was supported by both the Independent Living Centers and long-term care providers involved in the application process, and is one that they will both partner with the state to successfully implement during the demonstration. This is but one example of why collaboration between these two entities is so vital to the entire process. It also demonstrates positive progress in the right direction.

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{Request}

4. Please provide more detailed information about your Quality Management System, particularly as to how it will relate to your demonstration. Your application states that the State utilizes the CMS Quality Framework, however, specific details supporting this statement are lacking.

*{Kansas Response}*

#### **Quality Management System**

Kansas has an extremely strong quality system based on the CMS Quality Framework. Strengthening of the cross waiver components of the system is an objective of the Real Choice Systems Transformation grant. Kansas will work with stakeholder groups to modify, develop and implement quality assurance and performance reporting tools, processes, and reporting structures. The goal is to identify trends across waivers and issues that are working well in one service component but that may be weak in others. [SRS Attachment 3 ] [KDOA Attachment 4 ] Additionally, the MFP project will ensure 100% quality and performance improvement monitoring of all MFP participants during the life of the demonstration project. The additional monitoring will focus on the CMS HCBS Waiver Assurances, consumer satisfaction and systemic performance improvement opportunities. The additional survey tool will be developed by the MFP Steering Committee (“Community Choice”).

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**Attachments:**

	<b><u>Page</u></b>
Rebalancing State Profile	22 - 37
Kansas SRS Quality Management Strategy	38 - 52
KDOA Quality Management Strategy	53 - 63
MFPBudgetForm.xls	Submitted in Separate Document

**REQUIRED ATTACHMENTS (Final Version)**

**Money Follows the Person**

**State Profile and Summary of Project**

**Name of State: Kansas**

**Primary Contact Name and Title: Frank A. Stahl, Assistant Director**

**Year of Demonstration: 2007 (Jan-Sept)** \_\_\_\_\_ (submit a separate form for each year the State purposes to transition individuals)

<b>Populations to be transitioned (unduplicated count)</b>	<b>Elderly</b>	<b>Mental Retardation/ Developmental Disability (MR/DD) (Private)</b>	<b>Mental Retardation/ Developmental Disability (MR/DD) (State)</b>	<b>Physical Disability (PD)</b>	<b>Traumatic Brain Injury (TBI)</b>
<b>Estimated number of individuals to be transitioned</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Statewide (SW) or Not Statewide (NSW)</b>	<b>SW</b>	<b>SW</b>	<b>SW</b>	<b>SW</b>	<b>SW</b>
<b>Qualified Institutional Settings*</b>	<b>Nursing Facilities</b>	<b>Private Intermediate Care Facilities for the Mentally Retarded</b>	<b>State Mental Retardation Hospitals</b>	<b>Nursing Facilities</b>	<b>Nursing Facilities</b>
<b>Qualified Community Settings**</b>	1.A home owned or leased by the individual or the individual's family member 2.An apartment with an individuals lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual	1.A home owned or leased by the individual or the individual's family member 2.An apartment with an individuals lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control 3.A residence, in a	1.A home owned or leased by the individual or the individual's family member 2.An apartment with an individuals lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control 3.A residence, in a	1.A home owned or leased by the individual or the individual's family member 2.An apartment with an individuals lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over	1.A home owned or leased by the individual or the individual's family member 2.An apartment with an individuals lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control.

	or the individual's family has domain and control.	community-based setting, in which no more than 4 unrelated individuals reside	community-based setting, in which no more than 4 unrelated individuals reside	which the individual or the individual's family has domain and control.	
<b>Qualified HCB Services</b>					
<b>HCB Demonstration Services</b>					
<b>Populations to be transitioned (unduplicated count)</b>	<b>Elderly</b>	<b>Mental Retardation/ Developmental Disability (MR/DD) (Private)</b>	<b>Mental Retardation/ Developmental Disability (MR/DD) (State)</b>	<b>Physical Disability (PD)</b>	<b>Traumatic Brain Injury (TBI)</b>
<b>Supplemental Demonstration Services</b>					

\* Please indicate one or more from the list. Do not list names of actual facilities. **a).** Hospital; **b).** Nursing Home; **c).** ICF/MR; **d).** IMDs)

\*\* Please indicate if participants are moving to: **a).** Homes owned or leased by the individual or the individual's family member; **b).** Apartment with individual leases, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or individual's family has domain and control; **c).** Residences, in a community-based residential setting, in which no more than four unrelated individuals reside.

**REQUIRED ATTACHMENTS (Final Version)**  
**Money Follows the Person**

**State Profile and Summary of Project**

**Name of State: Kansas**

**Primary Contact Name and Title: Frank A. Stahl, Assistant Director**

**Year of Demonstration: 2008** (submit a separate form for each year the State purposes to transition individuals)

<b>Populations to be transitioned (unduplicated count)</b>	<b>Elderly</b>	<b>Mental Retardation/ Developmental Disability (MR/DD) (Private)</b>	<b>Mental Retardation/ Developmental Disability (MR/DD) (State)</b>	<b>Physical Disability (PD)</b>	<b>Traumatic Brain Injury (TBI)</b>
<b>Estimated number of individuals to be transitioned</b>	92	28	5	121	20
<b>Statewide (SW) or Not Statewide (NSW)</b>	SW	SW	SW	SW	SW
<b>Qualified Institutional Settings*</b>	<b>Nursing Facilities</b>	<b>Private Intermediate Care Facilities for the Mentally Retarded</b>	<b>State Mental Retardation Hospitals</b>	<b>Nursing Facilities</b>	<b>Nursing Facilities</b>
<b>Qualified Community Settings**</b>	1.A home owned or leased by the individual or the individual's family member 2.An apartment with an individuals lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking	1.A home owned or leased by the individual or the individual's family member 2.An apartment with an individuals lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control	1.A home owned or leased by the individual or the individual's family member 2.An apartment with an individuals lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control	1.A home owned or leased by the individual or the individual's family member 2.An apartment with an individuals lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking	1.A home owned or leased by the individual or the individual's family member 2.An apartment with an individuals lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the

	areas over which the individual or the individual's family has domain and control.	3.A residence, in a community-based setting, in which no more than 4 unrelated individuals reside	3.A residence, in a community-based setting, in which no more than 4 unrelated individuals reside	areas over which the individual or the individual's family has domain and control.	individual's family has domain and control.
<b>Qualified HCB Services</b>	1.Adult Day Care 2.Assistive Technology 3. Personal Emergency Response Install and Rental 4.Medication Reminder Services 5.Nurse Evaluation Visit 6.Sleep Cycle Support 7.Wellness Monitoring	1.Personal Assistant Services (Amendment Pending) 2.Residential Supports 3.Respite Care 4.Supported Employment 6.Supportive Home Care 7.Wellness Monitoring 8.Assitive Services 9.Day Supports 10.Family Individual Supports 11.Medical Alert Rental Sleep Cycle Support 12.Overnight Respite Care 13.Oral Health	1.Personal Assistant Services (Amendment Pending) 2.Residential Supports 3.Respite Care 4.Supported Employment 6.Supportive Home Care 7.Wellness Monitoring 8.Assitive Services 9.Day Supports 10.Family Individual Supports 11.Medical Alert Rental Sleep Cycle Support 12.Overnight Respite Care 13.Oral Health	1.Personal Services 2.Assistive Services 3. Oral Health Services 4.Personal Emergency Response System and Installation 5.Sleep Cycle Support	1. Assistive Services 2.Behavior Therapy 3.Cognitive Rehabilitation 4.Drug and Alcohol Therapy 5.Occupational Therapy 6.Oral Health Services 7.Personal Emergency Response System and Installation 8.Personal Services 9.Physical Therapy 10.Sleep Cycle Support 11.Speech and Language Therapy 12.Transitional Living Skills
<b>HCB Demonstration Services</b>	1. Transition Service (start up costs)	1. Transition Service (start up costs)	1. Transition Service (start up costs)	1. Transition Service (start up costs)	1. Transition Service (start up costs)
	2. Home Modifications to ensure health safety and mobility costs that exceed current Waiver limitations	2. Home Modifications to ensure health safety and mobility costs that exceed current Waiver limitations	2. Home Modifications to ensure health safety and mobility costs that exceed current Waiver limitations	2. Home Modifications to ensure health safety and mobility costs that exceed current Waiver limitations	2. Home Modifications to ensure health safety and mobility costs that exceed current Waiver limitations
		3. Adaptive equipment /	3. Adaptive equipment /	3. Adaptive	3. Adaptive equipment /

		supplies including items not covered by a similar waiver service	supplies including items not covered by a similar waiver service	equipment / supplies including items not covered by a similar waiver service	supplies including items not covered by a similar waiver service
<b>Populations to be transitioned (unduplicated count)</b>	<b>Elderly</b>	<b>Mental Retardation/ Developmental Disability (MR/DD) (Private)</b>	<b>Mental Retardation/ Developmental Disability (MR/DD) (State)</b>	<b>Physical Disability (PD)</b>	<b>Traumatic Brain Injury (TBI)</b>
<b>Supplemental Demonstration Services</b>		1. Therapeutic support; including necessary technology to assure long term community integration and support.	1. Therapeutic support; including necessary technology to assure long term community integration and support.		1. Therapeutic support; including necessary technology to assure long term community integration and support.
	2. Community Bridge Building – the development of systems, supports and structures that will assure this person and others in the future have access to generic, community inclusive services.	2. Community Bridge Building – the development of systems, supports and structures that will assure this person and others in the future have access to generic, community inclusive services.	2. Community Bridge Building – the development of systems, supports and structures that will assure this person and others in the future have access to generic, community inclusive services.	2. Community Bridge Building – the development of systems, supports and structures that will assure this person and others in the future have access to generic, community inclusive services.	2. Community Bridge Building – the development of systems, supports and structures that will assure this person and others in the future have access to generic, community inclusive services.
		3. Staff training (certification) specific to the needs of the person leaving the institutional setting	3. Staff training (certification) specific to the needs of the person leaving the institutional setting		3. Staff training (certification) specific to the needs of the person leaving the institutional setting
		4. Licensed facility bed buyback - these beds would be permanently closed and the operator			

\* Please indicate one or more from the list. Do not list names of actual facilities. **a).** Hospital; **b).** Nursing Home; **c).** ICF/MR; **d).** IMDs)

\*\* Please indicate if participants are moving to: **a).** Homes owned or leased by the individual or the individual’s family member; **b).** Apartment with individual leases, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the

**REQUIRED ATTACHMENTS (Final Version)**  
**Money Follows the Person**

**State Profile and Summary of Project**

**Name of State: Kansas**

**Primary Contact Name and Title: Frank A. Stahl, Assistant Director**

**Year of Demonstration: 2009** (submit a separate form for each year the State purposes to transition individuals)

<b>Populations to be transitioned (unduplicated count)</b>	<b>Elderly</b>	<b>Mental Retardation/ Developmental Disability (MR/DD) (Private)</b>	<b>Mental Retardation/ Developmental Disability (MR/DD) (State)</b>	<b>Physical Disability (PD)</b>	<b>Traumatic Brain Injury (TBI)</b>
<b>Estimated number of individuals to be transitioned</b>	<b>50</b>	<b>45</b>	<b>10</b>	<b>78</b>	<b>10</b>
<b>Statewide (SW) or Not Statewide (NSW)</b>	<b>SW</b>	<b>SW</b>	<b>SW</b>	<b>SW</b>	<b>SW</b>
<b>Qualified Institutional Settings*</b>	<b>Nursing Facilities</b>	<b>Private Intermediate Care Facilities for the Mentally Retarded</b>	<b>State Mental Retardation Hospitals</b>	<b>Nursing Facilities</b>	<b>Nursing Facilities</b>
<b>Qualified Community Settings**</b>	1.A home owned or leased by the individual or the individual's family member 2.An apartment with an individuals lease, with lockable access and egress, and which includes	1.A home owned or leased by the individual or the individual's family member 2.An apartment with an individuals lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the	1.A home owned or leased by the individual or the individual's family member 2.An apartment with an individuals lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the	1.A home owned or leased by the individual or the individual's family member 2.An apartment with an individuals lease, with lockable access and egress, and which includes	1.A home owned or leased by the individual or the individual's family member 2.An apartment with an individuals lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking

	living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control.	individual's family has domain and control 3.A residence, in a community-based setting, in which no more than 4 unrelated individuals reside	individual's family has domain and control 3.A residence, in a community-based setting, in which no more than 4 unrelated individuals reside	living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control.	areas over which the individual or the individual's family has domain and control.
<b>Qualified HCB Services</b>	1.Adult Day Care 2.Assistive Technology 3. Personal Emergency Response Install and Rental 4.Medication Reminder Services 5.Nurse Evaluation Visit 6.Sleep Cycle Support 7.Wellness Monitoring	1.Personal Assistant Services (Amendment Pending) 2.Residential Supports 3.Respite Care 4.Supported Employment 6.Supportive Home Care 7.Wellness Monitoring 8.Assistive Services 9.Day Supports 10.Family Individual Supports 11.Medical Alert Rental Sleep Cycle Support 12.Overnight Respite Care 13.Oral Health	1.Personal Assistant Services (Amendment Pending) 2.Residential Supports 3.Respite Care 4.Supported Employment 6.Supportive Home Care 7.Wellness Monitoring 8.Assistive Services 9.Day Supports 10.Family Individual Supports 11.Medical Alert Rental Sleep Cycle Support 12.Overnight Respite Care 13.Oral Health	1.Personal Services 2.Assistive Services 3. Oral Health Services 4.Personal Emergency Response System and Installation 5.Sleep Cycle Support	1. Assistive Services 2.Behavior Therapy 3.Cognitive Rehabilitation 4.Drug and Alcohol Therapy 5.Occupational Therapy 6.Oral Health Services 7.Personal Emergency Response System and Installation 8.Personal Services 9.Physical Therapy 10.Sleep Cycle Support 11.Speech and Language Therapy 12.Transitional Living Skills
<b>HCB Demonstration Services</b>	1. Transition Service (start up costs)	1. Transition Service (start up costs)	1. Transition Service (start up costs)	1. Transition Service (start up costs)	1. Transition Service (start up costs)
	2. Home Modifications to ensure health safety and mobility costs that exceed current	2. Home Modifications to ensure health safety and mobility costs that exceed current Waiver limitations	2. Home Modifications to ensure health safety and mobility costs that exceed current Waiver limitations	2. Home Modifications to ensure health safety and mobility costs that exceed	2. Home Modifications to ensure health safety and mobility costs that exceed current Waiver limitations

	Waiver limitations			current Waiver limitations	
		3. Adaptive equipment / supplies including items not covered by a similar waiver service	3. Adaptive equipment / supplies including items not covered by a similar waiver service	3. Adaptive equipment / supplies including items not covered by a similar waiver service	3. Adaptive equipment / supplies including items not covered by a similar waiver service
<b>Populations to be transitioned (unduplicated count)</b>	<b>Elderly</b>	<b>Mental Retardation/ Developmental Disability (MR/DD) (Private)</b>	<b>Mental Retardation/ Developmental Disability (MR/DD) (State)</b>	<b>Physical Disability (PD)</b>	<b>Traumatic Brain Injury (TBI)</b>
<b>Supplemental Demonstration Services</b>		1. Therapeutic support; including necessary technology to assure long term community integration and support.	1. Therapeutic support; including necessary technology to assure long term community integration and support.		1. Therapeutic support; including necessary technology to assure long term community integration and support.
	2. Community Bridge Building – the development of systems, supports and structures that will assure this person and others in the future have access to generic, community inclusive services.	2. Community Bridge Building – the development of systems, supports and structures that will assure this person and others in the future have access to generic, community inclusive services.	2. Community Bridge Building – the development of systems, supports and structures that will assure this person and others in the future have access to generic, community inclusive services.	2. Community Bridge Building – the development of systems, supports and structures that will assure this person and others in the future have access to generic, community inclusive services.	2. Community Bridge Building – the development of systems, supports and structures that will assure this person and others in the future have access to generic, community inclusive services.
		3. Staff training (certification) specific to the needs of the person leaving the institutional setting	3. Staff training (certification) specific to the needs of the person leaving the institutional setting		3. Staff training (certification) specific to the needs of the person leaving the institutional setting
		4. Licensed facility bed buyback - these beds would be permanently closed and the operator			

\* Please indicate one or more from the list. Do not list names of actual facilities. **a).** Hospital; **b).** Nursing Home; **c).** ICF/MR; **d).** IMDs)

\*\* Please indicate if participants are moving to: **a).** Homes owned or leased by the individual or the individual's family member; **b).** Apartment with individual leases, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the

**REQUIRED ATTACHMENTS (Final Version)**  
**Money Follows the Person**

**State Profile and Summary of Project**

**Name of State: Kansas**

**Primary Contact Name and Title: Frank A. Stahl, Assistant Director**

**Year of Demonstration: 2010** (submit a separate form for each year the State purposes to transition individuals)

<b>Populations to be transitioned (unduplicated count)</b>	<b>Elderly</b>	<b>Mental Retardation/ Developmental Disability (MR/DD) (Private)</b>	<b>Mental Retardation/ Developmental Disability (MR/DD) (State)</b>	<b>Physical Disability (PD)</b>	<b>Traumatic Brain Injury (TBI)</b>
<b>Estimated number of individuals to be transitioned</b>	<b>50</b>	<b>59</b>	<b>30</b>	<b>78</b>	<b>10</b>
<b>Statewide (SW) or Not Statewide (NSW)</b>	<b>SW</b>	<b>SW</b>	<b>SW</b>	<b>SW</b>	<b>SW</b>
<b>Qualified Institutional Settings*</b>	<b>Nursing Facilities</b>	<b>Private Intermediate Care Facilities for the Mentally Retarded</b>	<b>State Mental Retardation Hospitals</b>	<b>Nursing Facilities</b>	<b>Nursing Facilities</b>
<b>Qualified Community Settings**</b>	1.A home owned or leased by the individual or the individual's family member 2.An apartment with an individuals lease, with lockable access and egress, and which includes	1.A home owned or leased by the individual or the individual's family member 2.An apartment with an individuals lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the	1.A home owned or leased by the individual or the individual's family member 2.An apartment with an individuals lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the	1.A home owned or leased by the individual or the individual's family member 2.An apartment with an individuals lease, with lockable access and egress, and which includes	1.A home owned or leased by the individual or the individual's family member 2.An apartment with an individuals lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking

	living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control.	individual's family has domain and control 3.A residence, in a community-based setting, in which no more than 4 unrelated individuals reside	individual's family has domain and control 3.A residence, in a community-based setting, in which no more than 4 unrelated individuals reside	living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control.	areas over which the individual or the individual's family has domain and control.
<b>Qualified HCB Services</b>	1.Adult Day Care 2.Assistive Technology 3. Personal Emergency Response Install and Rental 4.Medication Reminder Services 5.Nurse Evaluation Visit 6.Sleep Cycle Support 7.Wellness Monitoring	1.Personal Assistant Services (Amendment Pending) 2.Residential Supports 3.Respite Care 4.Supported Employment 6.Supportive Home Care 7.Wellness Monitoring 8.Assitive Services 9.Day Supports 10.Family Individual Supports 11.Medical Alert Rental Sleep Cycle Support 12.Overnight Respite Care 13.Oral Health	1.Personal Assistant Services (Amendment Pending) 2.Residential Supports 3.Respite Care 4.Supported Employment 6.Supportive Home Care 7.Wellness Monitoring 8.Assitive Services 9.Day Supports 10.Family Individual Supports 11.Medical Alert Rental Sleep Cycle Support 12.Overnight Respite Care 13.Oral Health	1.Personal Services 2.Assistive Services 3. Oral Health Services 4.Personal Emergency Response System and Installation 5.Sleep Cycle Support	1. Assistive Services 2.Behavior Therapy 3.Cognitive Rehabilitation 4.Drug and Alcohol Therapy 5.Occupational Therapy 6.Oral Health Services 7.Personal Emergency Response System and Installation 8.Personal Services 9.Physical Therapy 10.Sleep Cycle Support 11.Speech and Language Therapy 12.Transitional Living Skills
<b>HCB Demonstration Services</b>	1. Transition Service (start up costs)	1. Transition Service (start up costs)	1. Transition Service (start up costs)	1. Transition Service (start up costs)	1. Transition Service (start up costs)
	2. Home Modifications to ensure health safety and mobility costs that exceed current	2. Home Modifications to ensure health safety and mobility costs that exceed current Waiver limitations	2. Home Modifications to ensure health safety and mobility costs that exceed current Waiver limitations	2. Home Modifications to ensure health safety and mobility costs that exceed	2. Home Modifications to ensure health safety and mobility costs that exceed current Waiver limitations

	Waiver limitations			current Waiver limitations	
		3. Adaptive equipment / supplies including items not covered by a similar waiver service	3. Adaptive equipment / supplies including items not covered by a similar waiver service	3. Adaptive equipment / supplies including items not covered by a similar waiver service	3. Adaptive equipment / supplies including items not covered by a similar waiver service
<b>Populations to be transitioned (unduplicated count)</b>	<b>Elderly</b>	<b>Mental Retardation/ Developmental Disability (MR/DD) (Private)</b>	<b>Mental Retardation/ Developmental Disability (MR/DD) (State)</b>	<b>Physical Disability (PD)</b>	<b>Traumatic Brain Injury (TBI)</b>
<b>Supplemental Demonstration Services</b>		1. Therapeutic support; including necessary technology to assure long term community integration and support.	1. Therapeutic support; including necessary technology to assure long term community integration and support.		1. Therapeutic support; including necessary technology to assure long term community integration and support.
	2. Community Bridge Building – the development of systems, supports and structures that will assure this person and others in the future have access to generic, community inclusive services.	2. Community Bridge Building – the development of systems, supports and structures that will assure this person and others in the future have access to generic, community inclusive services.	2. Community Bridge Building – the development of systems, supports and structures that will assure this person and others in the future have access to generic, community inclusive services.	2. Community Bridge Building – the development of systems, supports and structures that will assure this person and others in the future have access to generic, community inclusive services.	2. Community Bridge Building – the development of systems, supports and structures that will assure this person and others in the future have access to generic, community inclusive services.
		3. Staff training (certification) specific to the needs of the person leaving the institutional setting	3. Staff training (certification) specific to the needs of the person leaving the institutional setting		3. Staff training (certification) specific to the needs of the person leaving the institutional setting

\* Please indicate one or more from the list. Do not list names of actual facilities. **a).** Hospital; **b).** Nursing Home; **c).** ICF/MR; **d).** IMDs)

\*\* Please indicate if participants are moving to: **a).** Homes owned or leased by the individual or the individual’s family member; **b).** Apartment with individual leases, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the

**REQUIRED ATTACHMENTS (Final Version)  
Money Follows the Person**

**State Profile and Summary of Project**

**Name of State: Kansas**

**Primary Contact Name and Title: Frank A. Stahl, Assistant Director**

**Year of Demonstration: 2011** (submit a separate form for each year the State purposes to transition individuals)

<b>Populations to be transitioned (unduplicated count)</b>	<b>Elderly</b>	<b>Mental Retardation/ Developmental Disability (MR/DD) (Private)</b>	<b>Mental Retardation/ Developmental Disability (MR/DD) (State)</b>	<b>Physical Disability (PD)</b>	<b>Traumatic Brain Injury (TBI)</b>
<b>Estimated number of individuals to be transitioned</b>	<b>50</b>	<b>59</b>	<b>50</b>	<b>79</b>	<b>10</b>
<b>Statewide (SW) or Not Statewide (NSW)</b>	<b>SW</b>	<b>SW</b>	<b>SW</b>	<b>SW</b>	<b>SW</b>
<b>Qualified Institutional Settings*</b>	<b>Nursing Facilities</b>	<b>Private Intermediate Care Facilities for the Mentally Retarded</b>	<b>State Mental Retardation Hospitals</b>	<b>Nursing Facilities</b>	<b>Nursing Facilities</b>
<b>Qualified Community Settings**</b>	1.A home owned or leased by the individual or the individual's family member 2.An apartment with an individuals lease, with lockable access and egress, and which includes	1.A home owned or leased by the individual or the individual's family member 2.An apartment with an individuals lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the	1.A home owned or leased by the individual or the individual's family member 2.An apartment with an individuals lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the	1.A home owned or leased by the individual or the individual's family member 2.An apartment with an individuals lease, with lockable access and egress, and which includes	1.A home owned or leased by the individual or the individual's family member 2.An apartment with an individuals lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking

	living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control.	individual's family has domain and control 3.A residence, in a community-based setting, in which no more than 4 unrelated individuals reside	individual's family has domain and control 3.A residence, in a community-based setting, in which no more than 4 unrelated individuals reside	living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control.	areas over which the individual or the individual's family has domain and control.
<b>Qualified HCB Services</b>	1.Adult Day Care 2.Assistive Technology 3. Personal Emergency Response Install and Rental 4.Medication Reminder Services 5.Nurse Evaluation Visit 6.Sleep Cycle Support 7.Wellness Monitoring	1.Personal Assistant Services (Amendment Pending) 2.Residential Supports 3.Respite Care 4.Supported Employment 6.Supportive Home Care 7.Wellness Monitoring 8.Assitive Services 9.Day Supports 10.Family Individual Supports 11.Medical Alert Rental Sleep Cycle Support 12.Overnight Respite Care 13.Oral Health	1.Personal Assistant Services (Amendment Pending) 2.Residential Supports 3.Respite Care 4.Supported Employment 6.Supportive Home Care 7.Wellness Monitoring 8.Assitive Services 9.Day Supports 10.Family Individual Supports 11.Medical Alert Rental Sleep Cycle Support 12.Overnight Respite Care 13.Oral Health	1.Personal Services 2.Assistive Services 3. Oral Health Services 4.Personal Emergency Response System and Installation 5.Sleep Cycle Support	1. Assistive Services 2.Behavior Therapy 3.Cognitive Rehabilitation 4.Drug and Alcohol Therapy 5.Occupational Therapy 6.Oral Health Services 7.Personal Emergency Response System and Installation 8.Personal Services 9.Physical Therapy 10.Sleep Cycle Support 11.Speech and Language Therapy 12.Transitional Living Skills
<b>HCB Demonstration Services</b>	1. Transition Service (start up costs)	1. Transition Service (start up costs)	1. Transition Service (start up costs)	1. Transition Service (start up costs)	1. Transition Service (start up costs)
	2. Home Modifications to ensure health safety and mobility costs that exceed current	2. Home Modifications to ensure health safety and mobility costs that exceed current Waiver limitations	2. Home Modifications to ensure health safety and mobility costs that exceed current Waiver limitations	2. Home Modifications to ensure health safety and mobility costs that exceed	2. Home Modifications to ensure health safety and mobility costs that exceed current Waiver limitations

	Waiver limitations			current Waiver limitations	
		3. Adaptive equipment / supplies including items not covered by a similar waiver service	3. Adaptive equipment / supplies including items not covered by a similar waiver service	3. Adaptive equipment / supplies including items not covered by a similar waiver service	3. Adaptive equipment / supplies including items not covered by a similar waiver service
<b>Populations to be transitioned (unduplicated count)</b>	<b>Elderly</b>	<b>Mental Retardation/ Developmental Disability (MR/DD) (Private)</b>	<b>Mental Retardation/ Developmental Disability (MR/DD) (State)</b>	<b>Physical Disability (PD)</b>	<b>Traumatic Brain Injury (TBI)</b>
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		3. Staff training (certification) specific to the needs of the person leaving the institutional setting	3. Staff training (certification) specific to the needs of the person leaving the institutional setting		3. Staff training (certification) specific to the needs of the person leaving the institutional setting
		4. Licensed facility bed buyback - these beds would be permanently closed and the operator			

\* Please indicate one or more from the list. Do not list names of actual facilities. **a).** Hospital; **b).** Nursing Home; **c).** ICF/MR; **d).** IMDs)

\*\* Please indicate if participants are moving to: **a).** Homes owned or leased by the individual or the individual's family member; **b).** Apartment with individual leases, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the



<b>ASSURANCE # 3 Provider qualifications Appendix C-3</b>					
<b>3.1 Qualified Providers (initial)</b>	a,b,f	1,2,3,4	a,b,c,d,e,f,g, h,i,j,k,l,m,n, o,p	1,2,3,4,6,9,10	!!
<b>3.2 Qualified Providers (on-going)</b>	a,b,f	1,2,3,4	a,b,c,d,e,f,g, h,i,j,k,l,m,n, o,p	1,2,3,4,6,9,10	!!
<b>3.3 Non-Lic / non-certified Providers</b>	a,b,f	1,2,3,4	a,b,c,d,e,f,g, h,i,j,k,l,m,n, o,p	1,2,3,4,6,9,10	!!
<b>3.4 Failure Remediation</b>	a,b,f	1,2,3,4	a,b,c,d,e,f,g, h,i,j,k,l,m,n, o,p	1,2,3,4,6,9,10	!!
<b>3.5 Provider Training Verification</b>	a,b,f	1,2,3,4	a,b,c,d,e,f,g, h,i,j,k,l,m,n, o,p	1,2,3,4,6,9,10	!!
<b>ASSURANCE # 4 Health and Welfare Appendix d-2 Appendix G</b>					
<b>4.1 Continuous monitoring of Health / Safety Remediation as required</b>	a,b,c,f	1,2,3,4	a,b,c,d,e,f,g, h,i,k,l,m,n	1,2,3,4,6,9,10	!!!!
<b>4.2 ANE Prevention</b>	a,b,c,f	1,2,3,4	a,b,c,d,e,f,g ,h,i,k,l,m,n	1,2,3,4,6,9,10	!!!!
<b>ASSURANCE # 5</b>					
<b>Administrative Authority</b> Appendix A	Ongoing Operating Agency Review  See page 10	5	Review of operating agency quality monitoring reports / trends and follow- up actions  R	KHPA	!!!
<b>ASSURANCE # 6</b>					
<b>Financial Accountability</b> Appendix I	Ongoing Operating Agency Review  See page 10	5	Review of operating agency quality monitoring reports / trends and follow- up actions  R	KHPA	!!!

<b>H.1 Discovery Method</b>		<b>LEDGEND FOR COLUMN FIVE - 2</b>
a.	On-Site observation	Conducted at the actual site where the services are received (furnished / conducted)

Observe		ie: in the home of the participant or at the employment site
b. Personal Interview	On-Site participant / family or legal guardian interview	Interview is conducted directly with the person receiving services by the QA or PI staff. Privacy and confidentiality is assured to degree possible. Family / legal guardian input is sought only with the consent of the participant or in the case of children or legal guardians.
c. Staff Interview	On-Site provider staff interview	Interview with direct care, program, case management (independent living) staff that have direct relationships with the person receiving / requesting the services.
d. Outcome Monitor	On-Site and In-Person performance outcomes monitoring	Methodology may vary depending on the outcome. If the desired outcome is that the person will earn increasing amounts of dollars, or increase benefits from the employer the monitoring would include conversation with the participant and review of check stubs. Or if the outcome was for the person to become more independent at setting and keeping community appointments such as hair styling or arranging transportation the monitoring would be by observation / interview.
e. Record	On-Site Records Review	Review of agency files / records
f. Desk	Off – Site Review of collected / requested records / files / data / billing documents	Any record that documents services provided, activity, billing or provider policy, etc.
<b>H.1 Discovery Frequency</b>		<b>LEDGEND FOR COLUMN FIVE - 3</b>
1. Random	Quarterly Random Sample	Random sample generated by a defined formulary to ensure random selection based on specific criteria
2. 100%	100 % Review - Annual	A review that utilizes 100% of all identified records, of the records of all persons serviced for a defined period
3. Targeted	Targeted (focused) Review	A review that is either utilized to identify specific information from a larger than normal sample or focused toward a specific geographic area or service type, or population grouping. Utilized to verify findings from other type of reviews.
4. Routine	Daily observation / review	The daily activity conducted as a routine process of approving the POC; reviewing the LOC, participating in person centered planning activities, conducting on-site and in-person observations, monitoring and interviewing
5. Quarterly	Presentation of data, trends, remediation actions proposed / taken. Presentation of Operating Agency policies for review / approval	Information is presented by the Medicaid Operating Agency to KHPA (SSMA) for review / approval.
6. On-going Activity / Event	System analysis / performance Activity that is identifiable both as a specific event / activity as well as “it just happens”	These activities will include the regular evaluation of <ul style="list-style-type: none"> <li>· provider quality / system review performance</li> <li>· state systems performance</li> </ul>

<b>H.1 Data / information used in Discovery</b>		<b>LEDGEND FOR COLUMN FIVE - 4</b>
A	Case records	

<b>B</b>	<b>POC/ Person Centered Plans</b>
<b>C</b>	<b>Individualized documentation</b>
<b>D</b>	<b>Provider policies</b>
<b>E</b>	<b>Implementation plans / Action plans</b>
<b>F</b>	<b>Risk planning / risk evaluation</b>
<b>G</b>	<b>Behavior management data / reports</b>
<b>H</b>	<b>Individual consumer opinion</b>
<b>I</b>	<b>Family / guardian opinion</b>
<b>J</b>	<b>Provider agency professional staff opinion</b>
<b>K</b>	<b>Direct care staff opinion</b>
<b>L</b>	<b>Monitoring / observation activities</b>
<b>M</b>	<b>Critical event reports / notices</b>
<b>N</b>	<b>Incident reports</b>
<b>O</b>	<b>Medication administration data / logs / reports</b>
<b>P</b>	<b>Inspection reports / drills / tests including the opinion of the persons receiving services.</b>
<b>Q</b>	<b>Financial records</b>
<b>R</b>	<b>Program wide data, analysis, trends, reports, development of provider qualifications, summary of provider training activities, identification of providers that fail to achieve minimal qualifications, identification of suspected fraud, abuse and misuse of public funds</b>

<b>H.2 Roles and Responsibilities of persons involved in measuring performance and requesting improvements:</b>		
	<b>Waiver Participant / family / guardian if appointed</b>	All quality and performance review activities are conducted with the active presence and involvement of the person receiving the services. The persons receiving services, their family and /or legal guardians provide the data point information regarding all points of review. Individuals receiving services, family and guardians are present on all QA oversight teams, system review teams and during the planning, development and evaluation of all QA and PI systems, process and activities conducted.
	<b>Qualified Providers of Waiver and other funded services</b>	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, 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.
	<b>Contracted Managing Entities (CDDO, CMHC, CIL, HHA)</b>	Each contracted entity has regulatory quality review / performance improvement / consumer satisfaction / and administrative services functional compliance requirements. These requirements are passed on to the contracted affiliated waiver and other funded service providers. The managing entity maintains a local quality review process with appropriate corrective action requests as determined necessary. The State of Kansas QA and PI review systems are in addition and complimentary to the local / regional managing entity QA and PI requirements.
	<b>HCP/CSS Performance Improvement Program Manager</b>	Oversight of all CSS program performance improvement activities, initiatives, policies & protocols and to trend all data, present reports to review teams and CSS management

	<b>HCP/CSS Quality Assurance Administrator</b>	Oversight for all CSS licensing, contract monitoring, ADA compliance, CDDO review and other “Basic Assurance” activities, if any, and as appropriate to that provider / waiver
	<b>HCP/CSS Regional field staff</b>	Provide on-site and in-person monitoring, data collection for all HCP Waivers and programs
	<b>HCP/CSS Quality / Performance Review Teams</b>	Select staff representing all SRS regions, chaired by Central Office staff. Responsible to review all data collected, all monitoring reports, quality assurance and performance activities, review reports of trended data
	<b>HCP/CSS Management</b>	Comprised of the HCP/CSS Director and Assistant Director, responsible to review trended data reports and submit to SRS Leadership as appropriate
	<b>SRS Performance Improvement Team</b>	Team comprised of SRS/HPC/CSS Central Office Performance Improvement & Quality Assurance Staff and SRS Regional Assistant Directors charged with the responsibility to develop / implement a data collection system that will correlate individual program data with SRS Outcomes. And report them to SRS/HCP/CSS
	<b>Quality Oversight Committee</b>	Responsible to provide Quality Systems oversight, review system, and make recommendations for possible revisions.
	<b>Kansas State Medicaid Authority - KHPA</b>	SRS provides regular reports that identify trends in provider performance / individual outcomes / provider qualifications / waiver performance / waiver policy changes / waiver administration changes / rates / service definitions / eligibility criteria / amendments
	<b>SRS Leadership</b>	Receive reports at a high level, make budget and program recommendations. Provide executive level coordination with the Kansas Health Policy Authority in the Authorities role as the Single State Medicaid Agency.
<b>H.2</b>	<b>ENTITY / PERSON involved in Discovery</b>	<b>LEDGEND FOR COLUMN FIVE - 5</b>
1	State (SRS Regional Quality Assurance staff at the regional level)	
2	State ( SRS Regional Performance Improvement staff at the regional level)	
3	State (SRS/HCP/CSS Central Office)	
4	Provider quality review (provider staff)	
5	Contracted assessment and evaluation entities, ie: University of Kansas and others	
6	Contracted MMIS system staff that conduct SURS Review, HCBS Special Services Team	
7	Attorney General Office Staff – Medicaid Fraud Unit	
8	Quality Oversight Committee (state staff and provider staff)	
9	TCM or ILC staff	
10	Waiver Participant / family / legal guardian if appointed	
<b>H.3</b>	<b>ENTITY / PERSON involved in trending / reporting and issuing requests for Performance Improvement Plans</b>	
1	Quality Review Oversight Committee (membership is composed of Quality Review & Performance Improvement staff assigned to 6 SRS regional offices, chaired by SRS/HCP/CSS staff including QA Administrator and PI Program Manager)	
2	Statewide Quality Review / Performance Review - Central Office SRS / HCP / CSS (membership is composed of Assistant Director – chair; Performance Improvement Program Manager; Quality Assurance Administrator; Waiver Program Managers)	
3	SRS/HCP/CSS – Director and agency leadership	
4	Kansas State Medicaid Agency Quality Review / Performance Review - KHPA Long Term Care Committee (membership KHPA – Chair; other KHAP staff; SRS Staff; KDOA Staff)	
<b>H.3</b>	<b>IMPROVEMENT PRIORITIES</b>	<b>LEDGEND FOR COLUMN SIX - 6</b>

!!!!	Immediate – Health/Welfare	Requires immediate notification of provider by SRS staff to require provider to employ immediate intervention to protect participants and ensure adequate safety	Follow-up conducted by state staff
!!!	High	Require the provider to address the issue(s) identified by state monitoring personal within a timeframe established on site / with discretion by state staff persons	Follow-up conducted by state staff
!!	Medium	Requires the provider to address quality / performance issues that are identified through the ongoing on-site monitoring / random survey / participant / staff interview or observation.	Follow-up conducted by state staff
!	Low	Suggestions that the provider review internal policies / procedures to determine how the issue can be appropriate addressed	Follow-up conducted by state staff

**H.4 Compilation and Communication of Quality Management Information**

See page 10

**H.5. Periodic Evaluation and Revision of the Quality Management Strategy**

**HCP/CSS Quality Management and Performance process / policy and protocol are reviewed annually and revised as determined appropriate.**

1	Review past years performance with Medicaid Authority
2	Review past years performance with all stakeholders
3	Make revisions determined to be appropriate
4	Propose policy changes if necessary, change protocols, change forms, make data base adjustments
5	Present final proposed changes to Medicaid Authority for approval
6	Incorporate into following years monitoring practices.
7	Evaluate for continued effectiveness (on-going)
8	Include in 373Q or other CMS reporting vehicles as determined appropriate

**Participant Access: Desired Outcome:**  
Individuals have ready access to Home and Community Based Services in Their Community

Legend - see end of document for description	H.1 Discovery Method	H.1 Discovery Frequency	H.1 Information Used	H.2 Discovery Entity	H.3 Improvement Priority
I.A <b>Information / Referral</b> Individuals and families can readily obtain information concerning the availability of HCBS, how to apply and, if desired, offered a referral	a,f	2,4,5,6	h,i,j,k	3,5,6	!!
<b>I.B. Intake &amp; Eligibility</b>					
I.B.1 <b>User-Friendly Processes</b> Intake and eligibility determination processes are understandable and user-friendly to individuals and families and there is assistance available in applying for HCBS	a,f	2,4,5,6	h,i,j,k	3,5,6	!!

<b>I.B.2 Eligibility Determination</b> Each individual's need and eligibility for HCBS are assessed and determined promptly. Waiver Appendix B-6	a,f	2,4,5,6	h,i,j,k	3,5,6	!!!
<b>I.B.3 Referral to Community Resources</b> Individuals who need services but are not eligible for HCBS are linked to other community resources.	a,f	2,4,5,6	h,i,j,k	3,5,6	!
<b>I.B.4 Individual Choice of HCBS</b> Each individual is given timely information about available services to exercise his or her choice in selecting between HCBS and institutional	a,f	2,4,5,6	h,i,j,k	3,5,6	!!!
<b>I.B.5 Prompt Initiation</b> Services are initiated promptly when the individual is determined eligible and selects HCBS	a,f	2,4,5,6	h,i,j,k	3,5,6	!
<b>Participant-Centered Service Planning and Delivery: <u>Desired Outcome:</u></b> Services and supports are planned and effectively implemented in accordance with each person's unique needs, expressed preferences and decisions concerning his/her life in the community.					
<b>Legend - see end of document for description</b>	<b>H.1 Discovery Method</b>	<b>H.1 Discovery Frequency</b>	<b>H.1 Information Used</b>	<b>H.2 Discovery Entity</b>	<b>H.3 Improvement Priority</b>
<b>II.A Person Centered Service Planning</b>					
<b>II.A.1 Assessment</b> Comprehensive information concerning each person's preferences and personal goals, needs and abilities, health status and other available supports is gathered and used in developing a personalized service plan. Waiver Appendix B-6	a,b,c,f	2,4,6	a,b,c,e,f,g, h,i,j,k,l,m,n	1,2,4,5	!!!
<b>II.A.2 Individual Decision Making</b> Information and support is available to help participants make informed selections among service options. Waiver Appendix B-7 Waiver Appendix D-1 Waiver Appendix D-2	a,b,c,f	2,4,6	a,d,h,i	1,2,4,5	!!
<b>II.A.3 Free Choice of Providers</b> Information and support is available to assist participants to freely choose among qualified providers.	a,b,c,f	2,4,5,6	a,d,h,i	1,2,4,5	!!
<b>II.A.4 Service Plan</b> Each person's plan comprehensively addresses his or her identified need of HCBS, health care and other services in accordance with his or her expressed personal preferences and goals.	a,b,c,f	2,4,6	a,b,c,e,f,g, ,h,i,j,k,l,m,n	1,3,4,5	!!!
<b>II.A.5 Participant Direction</b> Participants have the authority and are supported to direct and manage their own services to the extent they wish.	a,b,c,f	2,4,5,6	b,d,h,i	1,2,4,5,6	!

<b>II.B. Service Delivery</b>					
II.B.1 <b>Ongoing Service and Support Coordination</b> Person's have continuous access to assistance as needed to obtain and coordinate services and promptly address issues encountered in community living.	a,b,c.	1,2,4,6	a,b,c,e,f,g, h,i,j,k,l,m,n	1,4,5	!!!
II.B.2 <b>Service Provision</b> Services are furnished in accordance with the person's plan.	a,b,c	1,2,4,6	a,b,c,e,f,g, h,i,j,k,l,m,n	1,4,5	!!
II.B.3 <b>Ongoing Monitoring</b> Regular, systematic and objective methods – including obtaining the participant's feedback – are used to monitor the individual's well being, health status, and the effectiveness of HCBS in enabling the individual to achieve his or her personal goals.	a,b,c	2,4,6	a,b,c,e,f,g, h,i,j,k,l,m,n	1,4,5	!!
II.B.4 <b>Responsiveness to Changing Needs</b> Significant changes in the person's needs or circumstances promptly trigger consideration of modifications in his or her plan.	a,b,c	2,4,6	a,b,c,e,f,g, h,i,j,k,l,m,n	1,2,3,4,5	!!
<b>Provider Capacity and Capabilities: Desired Outcome:</b> There are sufficient HCBS providers and they possess and demonstrate the capacity to effectively serve participants.					
<b>Legend - see end of document for description</b>	<b>H.1 Discovery Method</b>	<b>H.1 Discovery Frequency</b>	<b>H.1 Information Used</b>	<b>H.2 Discovery Entity</b>	<b>H.3 Improvement Priority</b>
III.A. <b>Provider Networks and Availability</b> There are sufficient qualified agency and individual providers to meet the needs of participants in their communities	f	5,6	b,h,I,j,k	2,4,5,6	!
III.B. <b>Provider Qualifications</b> All HCBS agency and individual providers possess the requisite skills, competencies and qualification to support participants effectively. Waiver Appendix C-3 Waiver Appendix G-	a,b,f	1,2,4	a,b,c,d,e,f,g, h,i,j,k,l,m,n, o,p	1,4,5	!!
III.C. <b>Provider Performance</b> All HCBS providers demonstrate the ability to provide services and supports in an effective and efficient manner consistent with the individual's plan. Waiver Appendix C-3 Waiver Appendix G- Waiver Appendix H-	a,b,f	1,2,4	a,b,c,d,e,f,g, h,i,j,k,l,m,n, o,p	1,2,4,5	!!!
<b>Participant Safeguards: Desired Outcome:</b> Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.					
<b>Legend - see end of document for description</b>	<b>H.1 Discovery Method</b>	<b>H.1 Discovery Frequency</b>	<b>H.1 Information Used</b>	<b>H.2 Discovery Entity</b>	<b>H.3 Improvement Priority</b>

<b>IV.A. Risk &amp; Safety Planning</b> Participant risk and safety considerations are identified and potential interventions considered that promote independence and safety with the informed involvement of the participant.	a,b,c,f	2,4	a,b,c,d,e,f,g ,h,i,k,l,m,n	1,4,5	!!!!
<b>IV.B. Critical Incident Management</b> There are systematic safeguards in place that protect participants from critical incidents and other life-endangering situations.	a,b,c,f	2,4	a,b,c,d,e,f,g ,h,i,k,l,m,n	1,4,5	!!!!
<b>IV.C. Housing and Environment</b> The safety and security of the participant's living arrangement is assessed, risk factors are identified and modifications are offered to promote independence and safety in the home.	a,b,c,f	2,4	a,b,c,d,e,f,g ,h,i,k,l,m,n,p	1,4,5	!!!
<b>IV.D. Behavior Interventions</b> Behavior interventions – including chemical and physical restraints – are only used as a last resort and subject to rigorous oversight.	n/a	n/a	n/a	n/a	n.a
<b>IV.E. Medication Management</b> Medications are managed effectively and appropriately	a,b,c,f	2,4	a,b,c,d,f,g ,h,l,m,n,o	1,4,5	!!!!
<b>IV.F. Natural Disasters and Other Public Emergencies</b> There are safeguards in place to protect and support participants in the event of natural disasters or other public emergencies.	a,b,c,f	2,4	a,b,d,f,l,n,p	1,4,5	!!!!
<b>Participant Rights and Responsibilities: <u>Desired Outcome:</u></b> Participants receive support to exercise their rights and in accepting personal responsibilities					
<b>Legend - see end of document for description</b>	<b>H.1 Discovery Method / Technique</b>	<b>H.1 Discovery Frequency</b>	<b>H.1 Information Used</b>	<b>H.2 Discovery Entity</b>	<b>H.3 Improvement Priority</b>
<b>V.A. Civic and Human Rights</b> Persons are informed of and supported to freely exercise their fundamental constitutional and federal or state statutory rights.	a,b,c,f	2,4	a,b,c,d,h,i,j,l	1,4,5	!!
<b>V.B. Participant Decision Making Authority</b> Persons receive training and support to exercise and maintain their own decision-making authority.	a,b,c,f	2,4	a,b,c,d,h,i,j,l	1,4,5	!!
<b>V.C. Alternate Decision Making</b> Decisions to seek guardianship, surrogates or other mechanisms that take authority away from participants are considered only after a determination is made that no less intrusive measures are or could be available to meet the person's needs.	a,b,c,f	2,4	a,b,c,d,h,i,j,l	1,4,5	1
<b>V.D. Due Process</b> Participants are informed of and supported to freely exercise their Medicaid due process rights.	a,b,c,f	2,4,5	a,b,c,d,h,i,j,l	1,4,5,6	!
<b>V.E. Grievances</b> Participants are informed of how to register grievances and complaints	a,b,c,f	2,4,5	a,b,c,d,h,i,j,l	1,4,5,6	!

and supported in seeking their resolution. Grievances and complaints are resolved in a timely fashion.					
<b>Participant Outcomes and Satisfaction: <u>Desired Outcome:</u></b> Participants are satisfied with their services and achieve desired outcomes.					
<b>Legend - see end of document for description</b>	<b>H.1 Discovery Method</b>	<b>H.1 Discovery Frequency</b>	<b>H.1 Information Used</b>	<b>H.2 Discovery Entity</b>	<b>H.3 Improvement Priority</b>
<b>VI.A. Participant Satisfaction</b> Participants and family members, as appropriate, express level of satisfaction with their services and supports.	a,f	2,4	a,b,e,h,i,l,	1,2,4,5	!!!
<b>VI.B. Participant Outcomes</b> Services and supports lead to positive outcomes for each participant.	a,f	2,4	a,b,e,h,i,l,	1,2,4,5	!!!

**H.1.a: Level of Care (LOC Determination)**

- Level of care – LOC instrument was developed in Kansas by consumers the state agency and other stakeholders.
- Eligibility determination / level of care instrument is used by all LOC determination staff
- LOC determination staff receive INITIAL and ON-GOING training by the Medicaid Operating Agency - SRS/HCP/CSS
- 100% review and approve each plan of care, initial, changes based on need and choice, and annual thereafter - by SRS Central Office staff
- Quality Assurance Review - random sample review - by SRS Regional Field staff
- Performance standards developed in partnership with - consumers, advocates, provider orgs and state operating and authority agencies
- Data from on-site monitoring reviewed - by SRS Central Office staff
- Data evaluated / trends identified / reports generated - by SRS Central Office staff
- Reports compiled - by SRS Central Office staff
- Reports reviewed - by SRS Central Office staff - Director and Assistant Director
  - Provider agency staff
  - Targeted case manager
  - Quality oversight review committees
- Reports submitted to KHPA (SSMA) for review
  - Remediation (if any) taken - by SRS Central Office staff
  - Follow-up monitoring - by SRS Central Office staff
  - System Performance - including overall LOC determination process / quality monitoring process / performance improvement process / performance standards and remediation requirements are reviewed annually - by consumers (direct recipients of services), advocates and other stakeholders through the quality oversight committee with SRS/HCP/CSS staff.

**H.1.a: Service Plan**

- Targeted Case Manager or Independent Living Counselor develop a service a persons centered support plan or plan of care based on the DDP (MR/DD)or UAI (PD; TBI; TA) as assessment instruments. POC / PSCP (individualized plans identifying the needs, supports, services necessary) are developed in partnership with the individual (legal guardian)
- The individual is supported to make informed choices
  - o Services / supports
  - o Self-direction (employer and/or budget options, if available) [Individuals that choose the self-direct option are provided opportunities for training to more effectively handle the self-direct responsibilities. Are provided support in understanding the benefits / rights /limitations and the responsibilities and the potential liabilities of self-direction. Liabilities may include not having staff at all times, due to staff recruiting, retention or availability issues that are the individual's responsibility under self direction.]
  - o Provider / agency
  - o Case manager / Independent Living Counselor (Person is supported to make independent choice of self-direction or among providers regardless of the affiliation of the TCM / ILC)
- Choice is offered at least annually, regardless of current provider or self-direction, or at other life choice decision points, or any time at the request of the individual.
  - Choice is documented with the consumer signature and place for review in the case file / individual file
  - The POC / PCSP and choice are monitored by state quality review and / or performance improvement staff as a component of waiver assurance and minimum standards.
  - The POC / PCSP is modified to meet change in needs, eligibility, or preferences, or at least annually during the re-evaluation process

#### **H.1.c: Qualified Providers**

- Are established within each individual waiver service
- Are reviewed to determine compliance to established license, certification, education or individual performance criteria
- Evidence of continued certification, licensing, education is reviewed as presented by the individual / agency / entity providing the assurance
- SRS/HCP/CSS regional field staff provide regular / on-going / on-site and in-person monitoring of all services provided including the continuing qualification of providers
- Persons making the choice to self-direct often do not avail themselves of training / certifications required of provider agency staff. Under self-direction the individual does have great latitude regarding their determination of provider qualification.
- Individuals that choose the self-direct option are provided opportunities for training to more effectively handle the self-direct responsibilities. Are provided support in understanding the benefits / rights /limitations and the responsibilities and the potential liabilities of self-direction. Liabilities may include not having staff at all times, due to staff recruiting, retention or availability issues that are the individual's responsibility under self direction.

#### **H.1.d: Health & Welfare**

- As identified in the chart above

### **H.1.e: Administrative Authority**

- The State Medicaid Agency (SSMA) KHPA has a cooperative agreement with the Department of Social and Rehabilitation Services. The agreement does involve the oversight of SRS by KHPA to ensure that all consumers are receiving effective support / services that issues are effectively resolved and policies / guidelines are met.
- KHPA approves all 372 reports, and waiver amendments

### **H.1.f: Financial Accountability**

- SRS exerts financial oversight of all aspects of wavier services / programs. All HCBS Plans Of Care are individually reviewed and authorized. All POC changes require prior approval, except Oral Health services. Prior authorization process ensures that the participant’s health and welfare needs are met and any claims processing errors are identified prior to implementation.
- Quality Reviews are conducted on a regular basis by state quality assurance and performance improvement staff. Provider reviews assure that services delivered are billed and reimbursed. On-sight review with the consumer verifies that services authorized are delivered.
- Special reviews may be conducted with reasonable cause
- Random reviews are completed through the HSST and SURS unit (Fiscal Agent)
- SRS/HCP Management operations tracks expenditures for both agency reporting, state reporting and reporting to CMS through HPA

### **H.2: Roles and Responsibilities**

- Identified in the chart on page 3 & 4 of this document
- A “NON-CHART VERSION” of the identical information contained in the chart is provided below:

#### **Waiver Participant / family / guardian if appointed**

All quality and performance review activities are conducted with the active presence and involvement of the person receiving the services. The persons receiving services, their family and /or legal guardians provide the data point information regarding all points of review. Individuals receiving services, family and guardians are present on all QA oversight teams, system review teams and during the planning, development and evaluation of all QA and PI systems, process and activities conducted.

#### **Qualified Providers of Waiver and other funded services**

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, 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.

#### **Contracted Managing Entities (CDDO, CMHC, CIL, HHA)**

Each contracted entity has regulatory quality review / performance improvement / consumer satisfaction / and administrative services functional compliance requirements. These requirements are passed on to the contracted affiliated waiver and other funded service providers. The managing entity maintains a local quality review process with appropriate corrective action requests as determined necessary. The State of Kansas QA and PI review systems are in addition and complimentary to the local / regional managing entity QA and PI requirements. These entities are made aware of all QA and PI results, and are party to any corrective action requests made of affiliated / contracted qualified service provider.

#### **HCP/CSS Performance Improvement Program Manager**

Oversight of all CSS program performance improvement activities, initiatives, policies & protocols and to trend all data, present reports to review teams and CSS management

**HCP/CSS Quality Assurance Administrator**

Oversight for all CSS licensing, contract monitoring, ADA compliance, CDDO review and other “Basic Assurance” activities, if any, and as appropriate to that provider / waiver

**HCP/CSS Regional field staff**

Provide on-site and in-person monitoring, data collection for all HCP Waivers and programs

**HCP/CSS Quality / Performance Review Teams**

Select staff representing all SRS regions, chaired by Central Office staff. Responsible to review all data collected, all monitoring reports, quality assurance and performance activities, review reports of trended data

**HCP/CSS Management**

Comprised of the HCP/CSS Director and Assistant Director, responsible to review trended data reports and submit to SRS Leadership as appropriate

**SRS Performance Improvement Team**

Team comprised of SRS/HPC/CSS Central Office Performance Improvement & Quality Assurance Staff and SRS Regional Assistant Directors charged with the responsibility to develop / implement a data collection system that will correlate individual program data with SRS Outcomes. And report them to SRS/HCP/CSS

**Quality Oversight Committee**

Responsible to provide Quality Systems oversight, review system, and make recommendations for possible revisions.

**Kansas State Medicaid Authority - KHPA**

SRS provides regular reports that identify trends in provider performance / individual outcomes / provider qualifications / waiver performance / waiver policy changes / waiver administration changes / rates / service definitions / eligibility criteria / amendments

**SRS Leadership**

Receive reports at a high level, make budget and program recommendations. Provide executive level coordination with the Kansas Health Policy Authority in the Authorities role as the Single State Medicaid Agency.

**H.3: Processes to Establish Priorities and Develop Strategies for Remediation and Improvement**

- KHPA and SRS work together to develop a state operating agency priority identification regarding all waiver assurances and minimum standards / basic assurances
- SRS works in partnership with consumers, advocacy organizations, provider groups and other interested stakeholders to tailor the performance standards, establish priorities for remediation and improvement this information is present to:
- Quality Assurance / Performance Oversight committees for discussion and approval and referred
- SRS/HCP/CSS for adoption / implementation and reporting with the approval of KHPA
- SRS/HCP/CSS maintains authority / right / responsibility to address any quality assurance issue to preserve health, safety, and program integrity

**H.4: Compilation and Communication of Quality Management Information**

- Reports developed quarterly, annual and annual comparison to past 1 to 5 year performance
- Reports provided to
  - o providers of services, consumers, and other interested parties

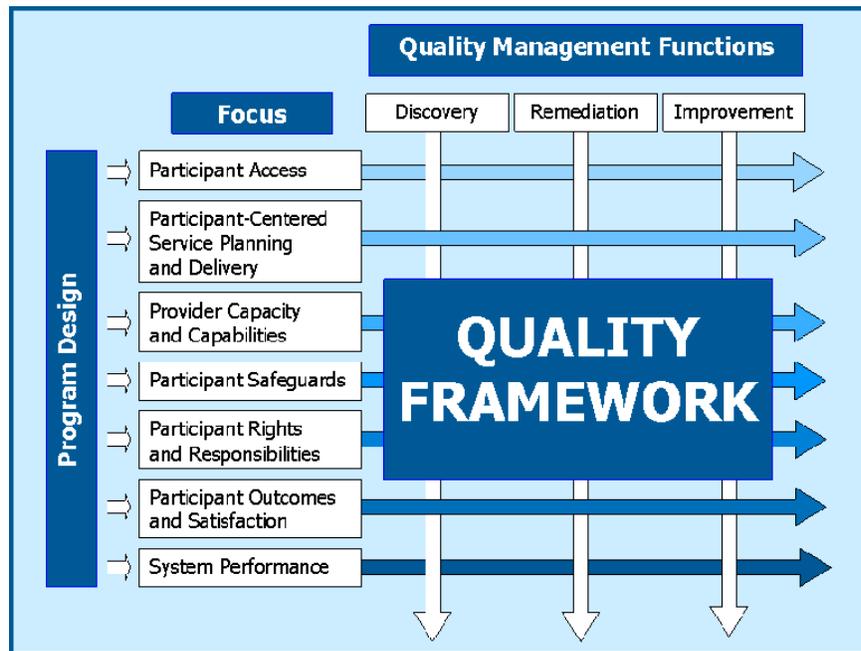
- o posted on the HCP/CSS web site [non-provider / non-consumer specific] In a primarily self-direct state provider comparison data is not as valuable as it might be in provider controlled services states
- Provider agencies are provided a specific trend analysis
- o Providers are required to identify corrective measures for all trends that fall below established performance standards
- Corrective responses are reviewed by
  - o Quality Oversight Committees
  - o HCP/CSS Performance Improvement and Quality Assurance managers / administrators
- Consolidated reports and trends are presented to KHPA (SSMA) quarterly for review and action as required

**H.5: Periodic Evaluation and Revision of the QMS**

- QMS specifically reviewed annually
- Review conducted by:
  - o Quality Oversight Committee (established in partnership with stakeholders – committee meets quarterly)
  - o HCP/CSS Performance Improvement and Quality Assurance staff – regional and statewide
- Recommended changes / modification / improvements to HCP/CSS management
  - Recommended / Approved modifications / changes / improvement present to KHPA (SSMA)

# Appendix H: Quality Management Strategy

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.



Quality Management is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement. A Quality Management Strategy explicitly describes the processes of discovery, remediation and improvement; the frequency of those processes; the source and types of information gathered, analyzed and utilized to measure performance; and key roles and responsibilities for managing quality.

CMS recognizes that a state's waiver Quality Management Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Management Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Management Strategy.

Quality management is dynamic and the Quality Management Strategy may, and probably will, change over time. Modifications or updates to the Quality Management Strategy shall be submitted to CMS in conjunction with the annual report required under the provisions of 42 CFR §441.302(h) and at the time of waiver renewal.

## Quality Management Strategy: Minimum Components

The Quality Management Strategy that will be in effect during the period of the waiver is included as Attachment #1 to Appendix H. The Quality Management Strategy should be no more than ten-pages in length. It may reference other documents that provide additional supporting information about specific elements of the Quality Management Strategy. Other documents that are cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

1. **The Quality Management Strategy must describe how the state will determine that each waiver assurance and requirement is met.** The applicable assurances and requirements are: (a) level of care determination; (b) service plan; (c) qualified providers; (d) health and welfare; (e) administrative authority; and, (f) financial accountability. For each waiver assurance, this description must include:
  - Activities or processes related to discovery, i.e. monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual and provider level of service delivery are provided in the application in Appendices A, B, C, D, G, and I. These monitoring activities provide a foundation for Quality Management by generating information that can be aggregated and analyzed to measure the overall system performance. The description of the Quality Management Strategy should not repeat the descriptions that are addressed in other parts of the waiver application;
  - The entities or individuals responsible for conducting the discovery/monitoring processes;
  - The types of information used to measure performance; and,
  - The frequency with which performance is measured.
2. **The Quality Management Strategy must describe roles and responsibilities of the parties involved in measuring performance and making improvements. Such parties include (but are not limited to) the waiver administrative entities identified in Appendix A, waiver participants, advocates, and service providers.**

*Roles and responsibilities may be described comprehensively; it is not necessary to describe roles and responsibilities assurance by assurance. This description of roles and responsibilities may be combined with the description of the processes employed to review findings, establish priorities and develop strategies for remediation and improvement as specified in #3 below.*
3. **Quality Management Strategy must describe the processes employed to review findings from its discovery activities, to establish priorities and to develop strategies for remediation and improvement.** *The description of these process(es) employed to review findings, establish priorities and develop strategies for remediation and improvement may be combined with the description of roles and responsibilities as specified in # 2 above.*
4. **The Quality Management Strategy must describe how the State compiles quality management information and the frequency with which the State communicates this information (in report or other forms) to waiver participants, families, waiver service providers, other interested parties, and the public.** *Quality management reports may be designed to focus on specific areas of concern; may be related to a specific location, type of service or subgroup of participants; may be designed as administrative management reports; and/or may be developed to inform stakeholders and the public.*
5. **The Quality Management Strategy must include periodic evaluation of and revision to the Quality Management Strategy. Include a description of the process and frequency for evaluating and updating the Quality Management Strategy.**

If the State's Quality Management Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Management Strategy, including the specific tasks that the State plans to undertake during the period that the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Management Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and identify the other long-term services that are addressed in the Quality Management Strategy.

## Attachment #1 to Appendix H

The Quality Management Strategy for the waiver is:

### **Level of Care (LOC) Determination**

The Kansas Department on Aging (KDOA) has developed a Uniform Assessment Instrument (UAI) to provide a comprehensive assessment of customers who need some type of community support services.

KDOA has just recently completed a four-year comprehensive reliability and validity study on the UAI. KDOA contracted with KUMC Center on Aging to conduct this study based on evidence-based criteria in the field of aging. As a result, minor changes have been made to continue with a valid and reliable tool for the assessment of seniors for community support services. All assessors were trained on the new definitions, background, forms, and interview techniques. Each assessor was mandated to attend and pass a test in order to continue with assessments beginning July 1, 2006.

All applicants for HCBS/FE shall be assessed using the UAI. The Long-Term Care Threshold Guide is used to calculate the participant's level of care score to determine functional eligibility. If the participant chooses HCBS/FE, the Customer Choice form must be completed and signed.

All HCBS/FE participants are evaluated at least annually. Completed assessments or annual reviews are valid up to 365 days unless there has been a significant change in condition that would necessitate a new assessment. At a minimum, the annual review shall be completed no later than the 365<sup>th</sup> day and shall include the following:

1. a new UAI;
2. a new Customer Service Worksheet (CSW), if necessary;
3. a new Plan of Care (POC), or if a new POC is not necessary, the existing POC signed and dated by the participant and TCM to indicate that it still applies;
4. a new Notice of Action (NOA) indicating continued eligibility;
5. a new ES-3161, which is sent to the SRS EES Specialist; and
6. the Customer Choice Form and the Customer's Rights and Responsibilities, signed and dated by both the participant and the Targeted Case Manager (TCM) to indicate that they have been reviewed.

The Area Agency on Aging (AAA) is required to data enter the initial and yearly review UAIs into Kansas Aging Management Information System (KAMIS).

KDOA Quality Reviewers conduct quarterly reviews based on a random sample on the case files against an established protocol for customer eligibility, informed choice and consistency of waiver forms. KDOA Quality Reviewers specifically review the case file to determine the customer's Long Term Care Score is calculated correctly, they are functionally eligible for HCBS/FE services, their Health & Welfare is met, and their annual re-determination has been completed.

KDOA Program Evaluation staff conducts a monthly data process to determine LOC

determinations are accurate. This adhoc report actually pulls data from the KAMIS system to identify LOCs that have been data entered that do not meet the minimum score. If errors are identified, the monthly reports are provided to the Program Manager who follows up with the TCM. Corrective action is taken by the TCM to remedy the problem.

### **Service Plan**

The Targeted Case Manager (TCM) uses the UAI as a comprehensive review of a participant's needs and resources, and it serves as a tool from which the participant and targeted case manager will develop the Plan of Care. The initial Plan of Care will be completed within seven working days of determination of the participant's eligibility for services. The Plan of Care is reviewed/revise at least annually, or as needed when there are health and welfare changes in the participant's condition or status. The TCM shall only approve the hours of services necessary to maintain the participant's health and welfare as documented on the CSW.

With the participant's approval, family members or other individuals designated by the participant are encouraged to participate, to the greatest extent possible, in the development and implementation of the Plan of Care. If the participant has a court appointed guardian/conservator or an activated durable power of attorney for health care decisions, the guardian/conservator or the holder of the activated durable power of attorney for health care decisions must be included and all necessary signatures documented on the POC.

When there is another individual living in the home, the TCM discusses, with the customer, what assistance the individual might provide in performing tasks, and document on the CSW and the POC as an informal support.

Targeted Case Managers make every effort to utilize/access all available services to meet the needs of their customers, not just those funded by their AAA. If participants choose HCBS/FE, this is indicated on the Customer Choice Form.

Whenever an individual is determined eligible for HCBS/FE services, the TCM must:

1. explain the Self-Directed Attendant Care Services Option and the rights and responsibilities of this option;
2. complete a Customer Choice form;
3. determine the need for waiver services after completing the CSW;
4. inform the participant of his/her rights and responsibilities regarding HCBS/FE.

The TCM completes appropriate forms indicating service tasks necessary to enable the participant to live safely in the most integrated environment possible. A physician's statement may be required if there is any question about physical disabilities or limitations.

Changes in functions, tasks, level of assistance or number of service hours on the participant's CSW require the approval of the TCM. Permanent changes to the frequency of service hours require prior TCM approval. All changes to the POC shall involve participant participation. When an unexpected change in the participant's social circumstances, mental status or medical

condition occurs which would affect the type, amount or frequency of services being provided during the authorization period, the TCM shall be responsible for making necessary changes in the authorization of services on a timely basis.

Ongoing evaluation and monitoring shall occur on a regular basis to assure services are being provided according to the POC, timely referrals are made on behalf of the customer, and when applicable “Client Obligation” issues for HCBS/FE are documented as changes occur.

In order to evaluate the POC, the TCM shall determine participant satisfaction with services and providers and review the appropriateness of the POC to ensure the participant's needs are being met.

A participant is eligible for HCBS/FE until such time as service providers or other resources are unavailable to implement all services on the POC. It is the responsibility of the TCM to identify and locate service providers and/or community resources.

KDOA reviews and authorizes each POC prior to implementation to ensure the service definitions and polices are followed appropriately. If issues are identified, the approver sends the POC back to the TCM with instructions for clarification or correction. On an ongoing basis, as changes are made to the POC to meet the participant’s health and welfare needs, an additional review and approval is completed by KDOA staff.

The KDOA Quality Review staff conduct quarterly interviews with the customer and/or family member in their home environment to determine that

1. the participant is satisfied with quality of care,
2. actual services have been delivered compared to the POC,
3. the participant was able to select the provider of their choice; and
4. health and welfare needs of the participant are being met.

If inadequacies are identified during the participant interview, the Quality Review interviewer completes a Referral and Response (R&R) form that is sent to the participant’s Targeted Case Manager. In addition, QR files a report with APS depending on the nature of the issue. There are three situations in which R&R forms are used:

- Critical: the participant is at risk and the situation requires immediate attention. After addressing the issue, the Targeted Case Manager sends a follow-up response to QR.
- Provider: a provider review indicates the participant is receiving less than 50% of the services authorized on the Plan of Care. After addressing the issue, the Targeted Case Manager sends a follow-up response to QR.
- Information: QR learned something in the interview that needs to be shared with the Targeted Case Manager. The Targeted Case Manager does not need to send a follow-up response to QR.

In addition to the above, the KDOA Program Evaluation Staff compiles on a quarterly basis all

Quality Review questions and responses into a management review report. These reports are thoroughly reviewed by KDOA Program staff for development of all training sessions conducted as ongoing quality improvement for the Targeted Case Managers. The Program Evaluation Unit also supplies the Program staff with a monthly service utilization report that is used for ongoing monitoring and follow-up with Targeted Case Managers as needed.

**Qualified Providers**

KDOA and Electronic Data System (EDS), the Fiscal Agent, work together to train providers and to monitor their status and activities.

Prior to enrollment, EDS verifies that potential service providers meet all State standards, including licensure and certification. EDS then notifies qualified providers of approval, and KDOA's Provider Manager sends a welcome letter offering technical assistance with meeting State standards.

The State of Kansas uses an ongoing survey and evaluation process to verify that providers continue to meet licensing and/or certification standards and adhere to other State standards. Long-Term Care facilities are licensed by KDOA. In-home care providers are licensed by the Kansas Department of Health and Environment (KDHE).

To monitor non-licensed/non-certified providers to assure adherence to waiver requirements, KDOA, Kansas Health Policy Authority (KHPA), EDS/SURS unit all serve on a HCBS Special Services Team (HSST). This team meets quarterly to review and address HCBS provider issues. The team also provides training to HCBS providers on documentation requirements. KDOA staff conducts additional training on waiver requirements as needed and requested by providers.

KDOA licensure unit has a process in place to notify the KDOA program manager when a facility license is voluntarily terminated or revoked. Once the license is terminated or revoked contact is made with EDS provider enrollment to ensure that providers who no longer meet the requirements as a qualified provider do not continue with active Medicaid enrollment.

**ROLE:**

HSST completes a post payment review on the provider to review documentation to ensure policy standards are followed. When the HSST unit determines that policy standards were not followed, a recoupment will be identified. The provider is notified in writing of the findings with an opportunity to send rebuttal documentation to EDS for further review. Once the additional documentation is reviewed a letter is again sent to the provider stating the recoupment amount and reasoning. The provider has the option to request an administrative reconsideration at which the program manager becomes involved to review the recoupment letter and documentation. Providers also have the choice of a fair hearing to allow the Office of Administrative Hearings to make the determination if the recoupment should stand or be revised.

**FREQUENCY:**

A quarterly HSST meeting is attended by KDOA, SRS, EDS, and KHPA. At each meeting

open cases are reviewed and updates given on provider reviews. Policies and Procedures are also reviewed and discussed to identify any changes being made or needing to be made to improve program design.

**ACTIONS TAKEN BY THE STATE TO REMEDY THE ISSUES:**

Issues that are frequently identified in these quarterly meetings are then incorporated into training for providers. KDOA has also worked with EDS/HSST unit to develop non-mandated documentation forms that providers may use. Technical assistance and training is offered after a provider audit.

**Health and Welfare**

KDOA Quality Reviewers are required to determine whether health and welfare needs of the participant are being met during the in-home participant interview and/or case file review. While reviewing the case file, case log notes will indicate whether a provider has contacted the case manager with health and welfare concerns. Whenever a quality reviewer encounters an HCBS/FE participant with an identifiable health and/or welfare issue, he or she shall do the following:

1. make a referral to SRS Adult Protective Services if, in the reviewer's and his or her supervisor's opinion, the issue involves abuse, neglect or exploitation of the customer;
2. report concerns to the TCM supervisor or contact person at the AAA if the situation is of concern but does not warrant, in the reviewer's opinion, an APS referral; and
3. complete a Referral and Response Form and mail it to the TCM Supervisor advising of the customer's situation and the critical issue (only situations identified as critical will require a response from the AAA, and QR will not follow up once the situation has been correctly referred).

On an ongoing basis, KDOA and the AAAs actively seek to identify and report instances of abuse, neglect and exploitation of the participants they serve. The Uniform Assessment Instrument (UAI) identifies a variety of environmental and behavioral factors that may put participants at risk. Questions are also asked about abuse, neglect and exploitation. KDOA and AAA Targeted Case Managers work closely with SRS Adult Protective Services to address issues and to report situations of concern. The AAA Targeted Case Managers, Home Health Agency staff, and Adult Care Home staff are mandated reporters of abuse, neglect, and exploitation.

SRS management is responsible for reviewing and monitoring all Adult Protective Services activity.

**Administrative Authority**

The State Medicaid Agency (KHPA) has a cooperative agreement with the KDOA. KHPA monitors the cooperative agreement through routine monthly meetings as well as other contacts when necessary. The monthly meetings are attended by program staff from both agencies. Issues, concerns, and current waiver activity are discussed. In addition, KHPA approves all waiver amendments and policy changes as well as receives the 372 reports prior to submission to CMS.

### **Financial Accountability**

KDOA exerts financial oversight during all stages of service provision. All HCBS/FE Plans of Care (POC) are reviewed and authorized by a KDOA POC Approver prior to initial service delivery. Any change to a POC also requires prior authorization. This prior authorization process ensures that the participant's health and welfare needs are met and that any claims processing errors are identified prior to implementation. Quality Reviews are also completed each quarter through a three-step process as follows:

- The provider review involves a three-month look back at paid claims for authorized services
- The participant interview assesses client choice, satisfaction with services, and whether health and welfare needs are met.
- The file review looks at case file documentation in comparison to Medicaid paid claims to ensure that paid units of service are accurate and billable.

Special reviews may also be completed at the request of the Fiscal Agent.

KDOA also tracks all POC expenditures through the Medicaid Management Information System (MMIS). From this data, monthly Standard Data Set (SDS) reports are created for ongoing monitoring purposes. In addition, KDOA exercises financial oversight of the waiver by producing a variety of reports projecting future expenditures based on payment trends.

### **Processes to Establish Priorities and Develop Strategies for Remediation and Improvement**

This description has been combined with the description of roles and responsibilities for the assurances. (H1, H2, H3 has been combined into one description.)

### **Compilation and Communication of Quality Management Information**

The **Standard Data Set (SDS)** addresses each AAA and statewide the number of participants, plan of care costs, number of service units provided and the expenditures for each service, HCBS Plans versus Customers with Service Amounts Allowed, Average HCBS Plan and Expended Amounts, Approved POCs Compared to Billed POCs, AAA Monthly Average Expenditure of POC Compared to Statewide Monthly Average Expenditure, and AAA Average Monthly POC Compared to Statewide Monthly Average POC. The SDS is produced monthly with the primary audience as the AAAs and KDOA program staff. Paper copies are mailed to the AAAs.

The **Plans of Care Summary** includes a summary for self directed plans, provider directed plans, and all plans combined. The topics for each of the categories includes the number of plans, % of Self Directed/Provider Directed to total, total POC cost, average plan of care, lowest POC cost, highest POC cost, Client Obligation amount, average LOC score, and average age. This report is produced monthly for KDOA Program staff.

The **Annual Report** includes the purpose/description of the program, number of participants receiving services by AAA, the total number of persons served and the total expenditure for the

fiscal year, the number of contracted service providers, demographics of the customers, the average cost per customer, trends, and a summary of the program outcomes. This report is produced annually for the primary audience of the Legislature. Each Legislator is mailed a hard copy of the report. However, this is also made available to stakeholders, providers, families, customers, and the general public as requested. Hard copies are available as well as on the agency website. KDOA also uses this document throughout the year as we administer the program.

The **HCBS POC Error Report** addresses any error or outlier of information for each POC in the KAMIS system. This report is produced quarterly for KDOA and the AAA Targeted Case Managers to assure accurate data in the management information system. This is disseminated through email to KDOA staff. Telephone calls and email responses are then initiated as needed to correct the error.

The **HCBS LOC Error Report** addresses LOCs in KAMIS that have been data entered below the minimum level of care for eligibility determination. The report is produced for the KDOA program manager to follow up through email and telephone contact with the AAA Targeted Case Manager to see where the error occurred. Corrective action is taken immediately to assure accurate data in KAMIS.

The **Quality Review Summary Report** addresses participants choice of providers, participant satisfaction with services, participant choice of self-direction or agency direction, participant rights and responsibilities, unmet needs, and health and welfare concerns. The report is compiled on a quarterly basis for use by the KDOA Program staff and AAAs to monitor improvement and make corrections where needed. Copies are provided to KDOA staff and mailed to the AAAs. Telephone calls and emails are used for corrective actions.

#### **Periodic Evaluation and Revision of the QMS**

KDOA management meets monthly with the AAA Directors. This meeting is used as a method to evaluate the HCBS/FE waiver policies and processes used in the administration. KDOA Program staff also meet with the TCM Supervisors as needed when it is necessary to discuss changes in priorities, changes in process, and changes with the monitoring protocol. KDOA Program staff meet at least once during the waiver period with the Quality Review staff and Program Evaluation Staff to modify the Quality Review Protocol based on changes needed to improve the monitoring process. As issues are identified during the normal daily operations, KDOA Program staff meet with the KDOA Program Evaluation staff to develop new data sources to assist in monitoring and correcting the issue. These reports may be temporary or on-going based on the issues identified.