

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

## PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

### 1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:  
The State of Kansas currently has an approved Technology Assisted(TA)Waiver through February 2009 to serve the target population of technology assisted and medically fragile persons with intensive medical needs.

Under CMS advisement, States may not target the specific population of technology assisted and medically fragile children currently served under the Attendant Care for Independent Living (ACIL), EPSDT State Plan service. In order to continue addressing the long-term medical needs of this population, the State of Kansas is requesting the following modifications to the current TA waiver:

- Increase the numbers of persons served from 48 to 407, unduplicated number of participants.
- Extend the age of eligibility for recipients from 0 through 17 years of age to 0 through 21 years of age.
- Add Long-term Community Care Attendant services in order to promote consumer choice and increase provider capacity
- Add Specialized Medical Care services; skilled nursing level of care
- Add home modification services
- Modification to language of the waiver definition and its existing services

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

### 1. Request Information (1 of 3)

- A. The State of Kansas requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).
- B. **Program Title** (*optional - this title will be used to locate this waiver in the finder*):  
**Technology Assisted Waiver**
- C. **Type of Request: renewal**

**Migration Waiver** - this is an existing approved waiver

**Renewal of Waiver:**

Provide the information about the original waiver being renewed

**Base Waiver Number:**

**Amendment Number**

(if applicable):

**Effective Date:** (mm/dd/yy)

**Waiver Number:** KS.4165.R04.00

**Draft ID:** KS.07.04.00

**Renewal Number:** 04

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

 Regular Waiver

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

**Approved Effective Date:** 08/01/08

**1. Request Information (2 of 3)**

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

**Hospital**

Select applicable level of care

**Hospital as defined in 42 CFR §440.10**

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

"Not applicable"

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

**Nursing Facility**

Select applicable level of care

**Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155**

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

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

**Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**

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

**1. Request Information (3 of 3)**

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

Select one:

**Not applicable**

**Applicable**

Check the applicable authority or authorities:

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

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

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

or previously approved:

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

- §1915(b)(1) (mandated enrollment to managed care)
- §1915(b)(2) (central broker)
- §1915(b)(3) (employ cost savings to furnish additional services)
- §1915(b)(4) (selective contracting/limit number of providers)
- A program authorized under §1115 of the Act.

Specify the program:

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## 2. Brief Waiver Description

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

The State of Kansas currently operates an approved waiver (control number 40165.90R2A), that provides services to eligible medical technology assisted and medically fragile children. The purpose for this waiver is to provide the opportunity for innovation in providing Home and Community Based Services (HCBS) to eligible persons who would otherwise require institutionalization in a hospital setting.

The goals and objectives of the waiver are consistent with the policy of the State to provide individuals who are medically fragile and require life-sustaining medical technology opportunities to live in the community in lieu of an institutional setting. This waiver provides access to long term care services intended to assist individuals in managing their healthcare limitations in order to maintain and progress to a productive life. This waiver provides opportunities for choices that increase an individual's independence, productivity, integration and inclusion in the community. The waiver is intended to provide supports and services to meet the medical needs of the individuals and will be provided in a manner that affords the same dignity and respect would be provided to any person who does not have a disability.

Technology assisted waiver participant will receive an initial assessment, a reassessment and an annual recertification for continued level of care eligibility determination using a standardized Medical Assistive Technology Level of Care (MATLOC) assessment instrument. The Program requires each participant receiving either agency-directed, participant-directed, or both agency and participant directed waiver services have a Plan of Care that identifies at a minimum: 1) Primary Diagnosis; 2) Technology (medical) needs; and 3) an individual service delivery plan which identifies frequency, scope and duration of long-term community medical support services. Re-assessment for waiver services is completed every six months and recertified annually.

Each waiver participants will have an individualized plan of care. The plan of care is developed by licensed medical professionals qualified to assess the healthcare needs of the individual. The plan of care will address issues and actions related to individual goals and objectives, access to (formal or informal) services, services to be provided, frequency, delivery method and providers of each of the services. All services will be furnished according to the written plan of care. The plan of care is subject to the approval of Social and Rehabilitation Services (SRS). Federal Financial Participation (FFP) will not be claimed for waiver services which are not included in the consumer's written Plan of Care.

Programmatic oversight and control of the waiver is provided by the Department of Social and Rehabilitation Services, Division of Disability and Behavioral Health Services/Community Supports and Services (SRS/DBHS/CSS). DBHS, through provider enrollment contracts with Independent case management entities across the state qualified to perform the level of care eligibility assessment, in addition will also coordinate access to services and monitor service provisions as defined by SRS/DBHS/CSS.

## 3. Components of the Waiver Request

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

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this

waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the State provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):
- Yes.** This waiver provides participant direction opportunities. Appendix E is required.

**No.** This waiver does not provide participant direction opportunities. Appendix E is not required.
- F. Participant Rights.** Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Management Strategy.** Appendix H contains the Quality Management Strategy for this waiver.
- I. Financial Accountability.** Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration.** Appendix J contains the State's demonstration that the waiver is cost-neutral.

#### 4. Waiver(s) Requested

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- A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.
- B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i) (III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):
- Not Applicable**
- No**
- Yes**
- C. Statewideness.** Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act (*select one*):
- No**
- Yes**

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

- Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:
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- Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make participant-direction of services as specified in Appendix E available only to individuals who reside in the

following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.

*Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:*

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## 5. Assurances

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

- A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
  2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
  3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
  2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for

this waiver.

- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

## 6. Additional Requirements

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

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are inpatients of a hospital, nursing facility or ICF/MR.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Management.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Management Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver: The Technology Assisted waiver was written following SRS/DBHS/CSS securing input from participants/parents/legal guardians of chronic technology assisted and medically fragile children, service providers, advocates and interested stakeholders. Public input is ongoing and requested from the parents/legal guardians, service providers and afore mentioned parties. DBHS/CSS meets with service providers on a quarterly basis and conducts an open public forum annually to consult and assemble information relative to the development and ongoing operations of the waiver program. Service providers and participants/parents/legal guardians are invited to submit recommendation to current or proposed policies and policy changes. In addition, public input is solicited on the SRS web site whenever proposed policies or policy changes specific to the TA waiver are considered.
- J. Notice to Tribal Governments.** The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.
- K. Limited English Proficient Persons.** The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

## 7. Contact Person(s)

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State:

Zip:

Phone:  Ext:   TTY

Fax: (785) 296-4813

E-mail: RSZH@srskansas.org

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

Last Name: Pierson

First Name: Kimberly

Title: Program Manager

Agency: Social Rehabilitation Services/Disability&amp;Behavioral Health Services/ Community Supports and Services

Address: DSOB 915 SW Harrison, 9th Floor

Address 2:

City: Topeka

State: Kansas

Zip: 66612-1570

Phone: (785) 368-6302

Ext:  TTY

Fax: (785) 296-0557

E-mail: kimberly.pierson@srs.ks.gov

**8. Authorizing Signature**

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

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

Signature: Rita Haverkamp

State Medicaid Director or Designee

Submission Date: Aug 14, 2008

Last Name: Allison

First Name: Andrew

Title: Director

Agency: Kansas Health Policy Authority

Address: 900 SW Jackson, Room 900N

Address 2:

City: Topeka

State: Kansas

Zip: 66612-1220

Phone:

(785) 296-3981

Fax:

(785) 296-4813

E-mail:

Andrew.allison@khpa.ks.org

**Attachment #1: Transition Plan**

Specify the transition plan for the waiver:

The current TA waiver provides case management and respite services for waiver eligible recipients. The case management services are limited to 120hrs/480 units per calendar year and the respite services are limited to 168 hrs/672 units per calendar year. The proposed modifications to the TA waiver renewal will not affect these services or its limitations for waiver participants currently receiving services under this waiver. Participants may continue to receive case management and respite services if he/she so chooses.

The modifications in the TA waiver renewal will provide opportunities for eligible waiver recipients the ability to choose from five waiver services versus the two current services offered under the existing TA waiver. The additional service choice will enable individual the flexibility to choose services that best fit their needs. Current and new TA waiver recipients will be eligible to receive independent case management and respite services, in addition recipients will benefit from three new services, the service and its limitations are as follows;

- Specialized Medical Care offers skilled nursing care to meet the ongoing medical needs of waiver recipients.
- Community Care Attendant offers self-directed personal attendant and agency-directed medical attendant level of care to meet the day to day needs of waiver recipients.
- Home modification provides waiver recipients opportunities to alter the home environment in order to assist individuals in adaptation of his/her physical limitations.

Individuals no longer meeting the level of care criteria for the waiver criteria for eligibility will be transitioned to other waiver programs or community programs and resources. Independent case management will be responsible for referring and facilitating access to alternate resources/services (including services under the State plan) if eligible in order to meet the needs of the individual.

The transition to alternate resources and services will need to be facilitated and completed within 45 days from the date of waiver ineligibility. Independent case management is responsible for informing individuals deemed ineligible for waiver services their appeal rights regarding the decision and request a fair hearing.

**Appendix A: Waiver Administration and Operation**

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

- The waiver is operated by the State Medicaid agency.

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one: do not complete Item A-2*):

- The Medical Assistance Unit.

Specify the unit name:

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

Specify the unit name:

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Do not complete item A-2.

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

Specify the unit name:

**The Department of Social and Rehabilitation Services**

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

## Appendix A: Waiver Administration and Operation

- 2. Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
- The single state Medicaid agency (SSMA) and SRS have an interagency agreement which, among other things:
- Specifies that the SSMA is the final authority on compensatory Medicaid costs.
  - Recognizes the responsibilities imposed upon the SSMA as the agency authorized to administer the Medicaid program, and the importance of ensuring that the SSMA retains final authority necessary to discharge those responsibilities.
  - Requires the SSMA approve all new contracts, MOUs, grants or other similar documents that involve the use of Medicaid funds.
  - Notes that the agencies will work in collaboration for the effective and efficient operation of Medicaid health care programs, including in the development and implementation of all program policies, and for the purpose of compliance with all required reporting and auditing of Medicaid programs.
  - Requires the SSMA to provide SRS with professional assistance and information; and both agencies to have designated liaisons to coordinate and collaborate through the policy implementation process.
  - Delegates to SRS the authority for administering and managing certain Medicaid funded programs, including those covered by this waiver application.
  - Specifies that the SSMA has final approval of regulations, SPAs and MMIS policies, is responsible for the policy process, and is responsible for the submission of applications/amendments to CMS in order to secure and maintain existing and proposed waivers, with SRS furnishing information, recommendations and participation. (The submission of this waiver application is an operational example of this relationship: Core concepts were developed through an interagency work group that involved program and operations staff from both the SSMA and SRS; functional pieces of the waiver were developed by SRS staff; and overview/approval of the submission was provided by the SSMA, after review by key administrative and operations staff and approval of both agencies' leadership.)

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

- a. A monthly meeting is held by the HPA with representatives from SRS to discuss:
  - Information received from CMS,
  - Proposed policy changes,
  - Waiver amendments and changes,
  - Data collected through the quality review process,
  - Eligibility, numbers of consumers being served,
  - Fiscal projections for the fiscal year, and
  - Any other topics related to the waivers and Medicaid.
- b. All policy changes related to the waivers are approved by the HPA. This process includes a face to face meeting with the HPA staff.
- c. Waiver renewals, 372 reports and requests for waiver amendments must be approved by the HPA.
- d. Correspondence with CMS is copied to the HPA.

**Appendix A: Waiver Administration and Operation**

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

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

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

Contracted independent waiver service case management providers will be utilized to perform the following operational and administrative functions on behalf of The Department of Social and Rehabilitation Services.

- Disseminate waiver information to potential consumers
- Conduct initial eligibility assessment, reassessments and ongoing evaluation activities for current and potential waiver participants.
- Assist waiver participants with enrollments
- Develop and review service plans, and
- Identify other waiver service providers to assure choice.

The state's fiscal agent conducts training and provides technical assistance with regard to waiver requirements.

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

**Appendix A: Waiver Administration and Operation**

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

**Not applicable**

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

Check each that applies:

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

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

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

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

**Appendix A: Waiver Administration and Operation**

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- 5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:  
Independent case managers of waiver services are responsible for the initial assessment, reassessment and ongoing monitoring of service provisions. The expected responsibility includes but is not limited to the following;

- Conduct initial assessment for level of care waiver eligibility determination
- Conduct level of needs assessment in order to determine service needs
- Develop individualized plans of care for waiver participants
- Coordinate services identified through the level of needs assessment and the plans of care
- Conduct ongoing coordination and monitoring of service provision

Social and Rehabilitation Services (SRS) is responsible for quality assurance and performance improvement of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions.

## Appendix A: Waiver Administration and Operation

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

Contracted entities are monitored through an HCBS-TA Quality Review process for the following functions:

- Disseminating information to potential waiver enrollees
- Assisting individuals in waiver enrollment
- Conducting Level of Care evaluation activities
- Reviewing consumer service plans to ensure waiver requirements are met, and
- Recruiting and coordination of service providers.

This process was developed to ensure that the contracting entities with SRS/DBHS/CSS, (the Waiver Operating Agency), were operating within the established parameters. The parameters include: CMS rules / guidelines; Kansas statutes and regulations; Medicaid provider enrollment contracts; and SRS/DBHS/CSS local/regional policies. The review is conducted on-site and face-to-face with consumers. The primary objective is to ensure that service providers assures points of review stated above and charted in A-7, as well as participant access, person centered Plans of Care and delivery, choice of services and service providers, assurance of adequate safeguards, and an appropriate methodology to assure that services for which the person is eligible are provided, and that services provided are paid for. The review also provides for ongoing oversight. Quality assurance reviews are completed by SRS/DBHS/CSS Regional Field Staff.

SRS/DBHS/CSS is empowered to utilize staged remedies / enforcement actions depending on severity of compliance issues, including recoupment of claims dollars. The individuals, guardians and families are key components of the review process as appropriate.

The state's fiscal agent conducts surveillance and utilization reviews of contracted entities based on referral. Meetings are held on a quarterly basis between SRS (the Waiver Operating Agency), the Medicaid agency, and the fiscal agent. The fiscal agent is also available to provide training and technical assistance to contracted entities on an as-needed basis. In addition, SRS/DBHS/CSS Regional Field staff maintain regular contact with, and monitor, the contracted entities, and conduct quality reviews on an annual basis.

Information obtained by SRS through the Quality Management plan, which includes information related to the performance of contractors is presented to the Kansas Health Policy Authority(KHPA). If recommendations for changes are made as a result of the quality reviews, SRS will review the outcomes with the KHPA, the Medicaid agency.

## Appendix A: Waiver Administration and Operation

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

each that applies):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Disseminate information concerning the waiver to potential enrollees	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Assist individuals in waiver enrollment	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Manage waiver enrollment against approved limits	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Monitor waiver expenditures against approved levels	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Conduct level of care evaluation activities	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Review participant service plans to ensure that waiver requirements are met	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Perform prior authorization of waiver services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Conduct utilization management functions	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Recruit providers	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Execute the Medicaid provider agreement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Determine waiver payment amounts or rates	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Conduct training and technical assistance concerning waiver requirements	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

**Appendix B: Participant Access and Eligibility**

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input checked="" type="radio"/> Aged or Disabled, or Both - General					
	<input type="checkbox"/>	Aged	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)	<input type="text"/>	<input type="text"/>	
	<input type="checkbox"/>	Disabled (Other)	<input type="text"/>	<input type="text"/>	
<input checked="" type="radio"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input checked="" type="checkbox"/>	Medically Fragile	0	21	<input type="checkbox"/>
	<input checked="" type="checkbox"/>	Technology Dependent	0	21	<input type="checkbox"/>
<input checked="" type="radio"/> Mental Retardation or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>

<input type="checkbox"/>	<input type="checkbox"/>	Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="radio"/> Mental Illness					
<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Serious Emotional Disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

A technology assisted and medically fragile individual age 0 through 21 years who is chronically ill or medically fragile and is dependent upon a ventilator or medical device to compensate for the loss of vital body function and requires substantial and ongoing daily care by a nurse comparable to the level of care provided in a hospital setting, or other qualified caregiver under the supervision of a nurse to avert death or further disability.

Furthermore, the individual is hospitalized, or at imminent risk of hospitalization, whose illness or disability, in the absence of home care services, would require admission to, or prolonged stay in a hospital.

The individual must be determined eligible for Medicaid.

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

Not applicable. There is no maximum age limit

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

*Specify:*

TA waiver recipients who are approaching their 22nd birthday will transition to the HCBS Physically Disabled (PD), Mental Retardation and Developmental Disability(MR/DD)or Traumatic Brain Injury (TBI)waiver provided the participant meet the established criteria and request to transition to other waiver services. Participants currently receiving waiver services will be assisted by his/her case manager in the process of transitioning to other eligible waiver services or community resources. The Case Manager will assist participants by providing information regarding other programs and services available to the participant/family so that they are able to make an informed choice. Case managers will assist the participant/family in accessing the chosen waiver programs or services and work with other program or service coordinators in order to ensure a smooth transition. The transition is complete once the participant is established with the new services.

The HCBS PD, MR/DD or TBI waiver program manager shall communicate the start date as the waiver participant approaches his/her 22nd birth date and the new Plan of Care costs to the SRS EES Specialist (the Medicaid eligibility worker) on or before the effective date of transfer. The waiver participant's Plan of Care costs are paid by the HCBS-Technology Assisted waiver until the participant's 22nd birthday.

## Appendix B: Participant Access and Eligibility

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

a. **Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*):

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

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

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

- A level higher than 100% of the institutional average.

Specify the percentage:

- Other

Specify:

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

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

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

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

- The following dollar amount:

Specify dollar amount:

The dollar amount (select one)

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

Specify the formula:

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

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

Specify percent:

- Other:

Specify:

**Appendix B: Participant Access and Eligibility**

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

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

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

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

- The participant is referred to another waiver that can accommodate the individual's needs.
- Additional services in excess of the individual cost limit may be authorized.

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

- Other safeguard(s)

Specify:

**Appendix B: Participant Access and Eligibility**

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	407
Year 2	412
Year 3	417
Year 4 (renewal only)	422
Year 5 (renewal only)	428

- b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number

of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

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

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	[ ]
Year 2	[ ]
Year 3	[ ]
Year 4 (renewal only)	[ ]
Year 5 (renewal only)	[ ]

**Appendix B: Participant Access and Eligibility**

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

- c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:
  - Not applicable. The state does not reserve capacity.
  - The State reserves capacity for the following purpose(s).

**Appendix B: Participant Access and Eligibility**

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

- d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:
  - The waiver is not subject to a phase-in or a phase-out schedule.
  - The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.
- e. **Allocation of Waiver Capacity.**

*Select one:*

- Waiver capacity is allocated/managed on a statewide basis.
- Waiver capacity is allocated to local/regional non-state entities.

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

--

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

To be eligible for the HCBS-TA Waiver, the individual must be chronically ill, medically fragile and is dependent upon a ventilator or medical device to compensate for the loss of vital body function and requires substantial and ongoing daily care by a nurse comparable to the level of care provided in a hospital setting. The individual must meet the functional eligibility requirement for this waiver.

To determine functional eligibility for entrance into the waiver, case managers will assess the level of care for the HCBS-TA waiver applicants using the Medical Assistive Technology Level of Care (MATLOC) assessment instrument. Entrance into the waiver is on first come first served basis and is subject to the MATLOC assessment completion, capacity allowed by funding and the approval by SRS/DBHS/CSS.

Financial eligibility for the HCBS-TA waiver is determined by Medicaid eligibility workers. Currently, Kansas will not be implementing a waiting list for this waiver.

## Appendix B: Participant Access and Eligibility

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

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

## Appendix B: Participant Access and Eligibility

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

- a. **State Classification.** The State is a (*select one*):
- §1634 State
  - SSI Criteria State
  - 209(b) State
- b. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

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

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

*Select one:*

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

Specify percentage:

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

- Working individuals with disabilities who buy into Medicaid (TWWIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
- Working individuals with disabilities who buy into Medicaid (TWWIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
- Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
- Medically needy
- Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)

Specify:

---

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

---

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

Select one and complete Appendix B-5.

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

Check each that applies:

- A special income level equal to:

Select one:

- 300% of the SSI Federal Benefit Rate (FBR)
- A percentage of FBR, which is lower than 300% (42 CFR §435.236)

Specify percentage:

- A dollar amount which is lower than 300%.

Specify dollar amount:

- Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)
- Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)
- Medically needy without spend down in 209(b) States (42 CFR §435.330)
- Aged and disabled individuals who have income at:

Select one:

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

Specify percentage amount:

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

Specify:

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (1 of 4)

*In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.*

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

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

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

- Use spousal post-eligibility rules under §1924 of the Act.  
(Complete Item B-5-b (SSI State) and Item B-5-d)
- Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)  
(Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)
- Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.  
(Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (2 of 4)

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

The State uses the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

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

- The following standard included under the State plan

Select one:

- SSI standard
- Optional State supplement standard
- Medically needy income standard
- The special income level for institutionalized persons

(select one):

- 300% of the SSI Federal Benefit Rate (FBR)
- A percentage of the FBR, which is less than 300%

Specify the percentage:

- A dollar amount which is less than 300%.

Specify dollar amount:

- A percentage of the Federal poverty level

Specify percentage:

- Other

Specify:

- The following dollar amount

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

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

Specify:

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

- Not Applicable (see instructions)
- SSI standard
- Optional State supplement standard
- Medically needy income standard
- The following dollar amount:

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

- The amount is determined using the following formula:

Specify:

[Empty text box]

iii. Allowance for the family (select one):

- Not Applicable (see instructions)
- AFDC need standard
- Medically needy income standard
- The following dollar amount:

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

- The amount is determined using the following formula:

Specify:

[Empty text box]

- Other

Specify:

[Empty text box]

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

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

Select one:

- Not Applicable (see instructions)
- The State does not establish reasonable limits.
- The State establishes the following reasonable limits

Specify:

[Empty text box]

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 4)

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

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

section is not visible.

**Appendix B: Participant Access and Eligibility**

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

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

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

**Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.**

**Appendix B: Participant Access and Eligibility**

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

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

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

**i. Minimum number of services.**

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

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

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

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

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

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

*Specify the entity:*

Case management entity who meets the qualification specified in appendix "C" and are enrolled as Medicaid providers will perform both evaluations and reevaluations for HCBS Technology Assisted waiver services.

- Other**  
Specify:

- c. Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

The case management entity shall meet the following minimum qualifications prior to performing the initial evaluation of level of care for waiver applicants:

- Advanced Registered Nurse (ARNP) or
  - Registered Nurse (RN) with a Bachelors degree
  - 2 years clinical experience in the nursing field
  - Hold a current license to practice in the capacity of a nurse in the State of Kansas
  - Enrolled as a Medicaid provider or must be employed under an enrolled Medicaid provider authorized to provide services under the HCBS-TA Waiver.
  - Must successfully pass KBI, APS, CPS, KSBN, and Motor Vehicle screen
- d. Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The case management entity will provide an initial evaluation and 6 months reevaluations of the need for the level(s) of care indicated in the waiver application.

The level of care criteria implemented for initial assessments of HCBS-Technology Assisted applicants is the same assessment conducted annually and at reassessment of HCBS-Technology assisted waiver. A waiver participants continued eligibility for waiver services is contingent upon the individual meeting the level of care criteria.

Case management entity will assess for level of care(LOC) eligibility, nursing and attendant care need is determined by conducting a level of care assessment utilizing the (MATLOC) instrument. The assessment will provide scoring for each medical technology and care element depicting the functional eligibility and level of medical needs for the waiver recipient.

The process for level of care(LOC) determination are as follows;

The case management entity conducts the Level of Care (functional eligibility) assessment of the individual applying for waiver services within ten(10) working days of the referral, an exception to the 10 working days may be granted by SRS if requested by the individual, family or legal representative applying for waiver services.

Following an assessment of the individual's primary technology and nursing acuity, the individual is deemed eligible if the following criteria are met;

- 1) Technology eligibility
    - Age 0-21 years with a minimum technology score of (50) points, or
    - Age 0 through 5 years with a minimum technology score of (25) points and a nursing acuity score of (20) points, or
    - Age 6 through 21 years with a minimum technology score of (25) points and an acuity score of (30) points.
  - 2) Participant is determined Medicaid eligible
  - 3) Reviewed and approved by the physician
  - 2) The assessment is reviewed and approved by the physician
- e. Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):
- The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
  - A different instrument is used to determine the level of care for the waiver than for institutional care under**

**the State plan.**

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

The MATLOC level of care instrument was adopted from the level of care instrument utilized by the State of Virginia Tech Waiver program in conjunction with the nursing acuity assessment instrument utilized by the State of Colorado program for the medically fragile.

The MATLOC level of care instrument was developed using existing assessments tools demonstrated by the State of Colorado and Virginia determined to be reliable and valid in assessing the participant's level of care. The instrument assesses the participant comprehensively by assessing the technology and medical needs.

The instrument has been presented to and approved by stakeholders; parents and providers who in the majority participate in the day to day care of the waiver target population.

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

The process for Level of Care reevaluation is the same as the process for Level of Care evaluation.

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

- Every three months
- Every six months
- Every twelve months
- Other schedule

*Specify the other schedule:*

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

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

*Specify the qualifications:*

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

The state employs the use of post pay reviews; MMIS review indicators (submitted with electronic Plans of Care); the use of the yearly reassessment as a component of the Case Manager; and edits in the computer system to ensure timely reevaluations of level of care.

In addition to the standard post pay reviews and utilization of the MMIS system to evaluate for timely redetermination of the waiver LOC eligibility. Following CMS recommendations in the TA waiver final review report in October 2007, Kansas is in the process of developing a database with a mechanism for monitoring and tracking the LOC eligibility redetermination every six months. Due to the redesign of the level of care instrument, the database is undergoing modifications to the previous design resulting in the delay of implementation. The database is targeted for completion in fall of 2008.

- j. Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §74.53. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained by the providers of case management who is responsible for performing the initial and reevaluation in the participant's case file for a minimum period of 3 years at the agencies designated as responsible for the performance of evaluations and reevaluations. The electronic plans of care will be maintained in the State of Kansas Medicaid Management Information System (MMIS).

## **Appendix B: Participant Access and Eligibility**

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### **B-7: Freedom of Choice**

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

- i. informed of any feasible alternatives under the waiver; and
  - ii. given the choice of either institutional or home and community-based services.
- a. **Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The state of Kansas assures CMS that when a participant is determined to be likely to require the level of care provided in a hospital. The participant, parent or legal guardian will be informed of any feasible alternative available under the waiver, and given the choice of either institutional or home and community-based services. (42CFR 441.302(d))

The following forms are employed to describe and to document freedom of choice:

- \* HCBS- Technology Assisted Waiver Referral and Service Choice Form
- \* Consumer Rights and Responsibilities

The case management provider is responsible for providing or explaining the freedom of choice and "Participant Rights and Responsibilities" to the participant, parent or legal guardian.

- b. **Maintenance of Forms.** Per 45 CFR §74.53, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Written copies or electronically retrievable facsimiles of Freedom of Choice documents are maintained by the case management entity responsible for offering the freedom of choice and determining eligibility per K.A.R 30-60-57. The parent or legal guardian signature on the Referral and Service Choice Form indicates and ensures participants or designee have been informed of the waiver options available.

## **Appendix B: Participant Access and Eligibility**

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

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

SRS has taken steps to assist staff in communicating with their Limited English Proficient Persons, and to meet the provisions set out in the Department of Health and Human Services Policy Guidance of 2000 requiring agencies which receive federal funding to provide meaningful access to services by Limited English Proficient Persons. In order to comply with federal requirements that individuals receive equal access to services provided by SRS and to determine the kinds of resources necessary to assist staff in ensuring meaningful communication with Limited English Proficient consumers, states are required to capture language preference information. This information is captured in the demographic section of the MATLOC instrument.

The State of Kansas defines prevalent non- English languages as languages spoken by significant number of potential enrollees and enrollees. Potential enrollee and enrollee materials will be translated into the prevalent non-English languages.

Each contracted provider is required by Kansas regulation to make every reasonable effort to overcome any barrier that consumers may have to receiving services, including any language or other communication barrier. This is achieved by having staff available to communicate with the consumer in his/her spoken language, and/or access to a phone-based translation services so that someone is readily available to communicate orally with the consumer in his/her spoken language. (K.A.R. 30-60-15).

**Appendix C: Participant Services**

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

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

Service Type	Service
Statutory Service	Independent Case Management
Statutory Service	Long-term Community Care Attendant Service
Statutory Service	Medical Respite Care
Other Service	Home Modification
Other Service	Specialized Medical Care

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

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

**Service Type:**

Statutory Service

**Service:**

Case Management

**Alternate Service Title (if any):**

Independent Case Management

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

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

**Service Definition (Scope):**

Providers of this service will assist individuals who receive waiver services in gaining access to needed waiver and Medicaid State plan services, as well as needed medical, social, educational and other services, regardless of funding source for the services to which access is gained. Case management service is provided by a qualified provider who serves the following functions:

- a. Serves as the point of access for waiver services
- b. Conducts preliminary screening to determine if referral is appropriate
- c. Administers initial assessment to determine functional eligibility and reassessment to determined continued eligibility
- d. Identify required service needs, locating and coordination of services
- e. Develop annual plans of care with clearly define goals based on the level of need assessed
- f. Monitoring the provisions of services and provide technical assistance to families and service providers to carry out program operations
- g. Ensure participant's plans of care are cost-effective and meet their medical needs as well as their basic health

and safety needs;

h. Ensure participant's freedom of choice of the waiver, its services and service providers

The majority of these contacts must occur in customary and usual community locations where the child lives, attend schools and/or childcare, and/or socializes. Services provided in an educational setting must not be educational in purpose. Services furnished to an individual who is an inpatient or resident of a hospital, nursing facility, intermediate care facility for persons with mental retardation, or institution for mental disease are non-covered.

The cost of transportation to conduct an initial and reassessment to and from the participant's place of residence and other services sites or places in the community is included in the reimbursement rate paid to providers of this services.

Where there is a potential for overlap, services must first be exhausted under IDEA or the Rehabilitation Act of 1973.

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

Case management services are limited to an average of 10 hours per month equating to 120 hours per calendar year(K.A.R. 30-5-77). Providers of case management under this waiver may not provide direct care services.

Exceptions to exceed the limit are subject to the approval of SRS.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Independent Case Manager
Agency	Independent Case Manager

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**  
**Service Name: Independent Case Management**

**Provider Category:**

Individual

**Provider Type:**

Independent Case Manager

**Provider Qualifications**

**License (specify):**

- Advanced Registered Nurse (ARNP)
- Registered Nurse (RN)

**Certificate (specify):**

Bachelors degree

**Other Standard (specify):**

- 2 years clinical experience in the nursing field
- Hold a current license to practice in the capacity of a nurse in the State of Kansas
- Enrolled as a Medicaid provider or must be employed under an enrolled Medicaid provider authorized to provide services under the HCBS-TA Waiver.

\*All standards, certifications and licenses that are required for the specific professional field through which service is provided including but not limited to: professional license / certification if required; adherence to DBHS/CSS training and professional development requirements; maintenance of clear background as evidenced through background checks of; KBI, APS, CPS, Kansas State Board of Nursing(KSBN), and Motor Vehicle screen

#### Verification of Provider Qualifications

##### Entity Responsible for Verification:

Kansas Health Policy Authority, SRS and SRS Regional Field staff are responsible for ensuring case management service provider is in compliance with the approved standards.

##### Frequency of Verification:

At a minimum, annually or more frequently as deemed necessary by KHPA, SRS and SRS Regional Field Staff.

## Appendix C: Participant Services

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

---

**Service Type: Statutory Service**

**Service Name: Independent Case Management**

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#### Provider Category:

Agency

#### Provider Type:

Independent Case Manager

#### Provider Qualifications

##### License (specify):

- Advanced Registered Nurse (ARNP)
- Registered Nurse (RN)

##### Certificate (specify):

Bachelors degree

##### Other Standard (specify):

- 2 years clinical experience in the nursing field
- Hold a current license to practice in the capacity of a nurse in the State of Kansas
- Enrolled as a Medicaid provider or must be employed under an enrolled Medicaid provider authorized to provide services under the HCBS-TA Waiver.

\*All standards, certifications and licenses that are required for the specific professional field through which service is provided including but not limited to:

- professional license / certification if required;
- adherence to DBHS/CSS training and professional development requirements;
- maintenance of clear background as evidenced through background checks of; KBI, APS, CPS, Kansas State Board of Nursing(KSBN), and Motor Vehicle screen

#### Verification of Provider Qualifications

##### Entity Responsible for Verification:

Kansas Health Policy Authority, SRS and SRS Regional Field staff are responsible for ensuring case management service provider is in compliance with the approved standards.

##### Frequency of Verification:

At a minimum, annually or more frequently as deemed necessary by KHPA, SRS and SRS Regional Field Staff.

## Appendix C: Participant Services

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### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request

through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Statutory Service

**Service:**

Personal Care

**Alternate Service Title (if any):**

Long-term Community Care Attendant Service

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

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

**Service Definition (Scope):**

Attendant services are available to individuals who choose to remain in their home while living with their medical limitations. This service provides necessary assistance for individuals both in their home and community.

Attendant service means care attendants assuring the health and welfare of the individual and supporting the individual with the tasks normally provided by their parents/ legal guardian or caretaker. The service is designed to assist individuals in performing a variety of personal tasks while promoting independence, productivity, and integration.

The functions of an attendant service includes but is not limited to assisting with activities of daily living – ADLs (bathing, grooming, toileting, transferring), health maintenance activities including but not limited to extension of therapies, feeding, mobility and exercises, socialization and recreation activities. The attendant care service supports the individual in accessing of medical services and normal daily activities by accompanying or providing transportation to accomplish tasks as listed within the scope of service.

Agency-directed attendant services will be coordinated by the Independent Case Manager and submitted in to the electronic plans of care for prior authorization and approval.

Self-directed attendant services will be arranged for, and purchased under the individual or legally responsible party's written authority, and paid through an enrolled fiscal agent consistent with and not exceeding the individual's Plan of Care.

Individuals will be permitted to choose qualified provider(s) who have passed the following background checks:

- KBI
- APS
- CPS
- Motor Vehicle Screening

Individual or legally responsible individual with the authority to direct services who may at some point determine that they no longer want to self-direct their Attendant service will have the opportunity to receive their previously approved waiver services, without penalty.

An attendant may not perform any duties not delegated by the individual with the authority to direct services or duties as approved by the participant's physician and must be identified as a necessary task in the plans of care.

An attendant may not be provided by the parent or legal guardian for the minor waiver recipient.

It is the expectation that waiver participants who need assistance with independent activities of daily living (IADL) tasks and who live with their parents or guardian capable of performing the IADL tasks, should rely on these informal/natural supporters for this assistance unless there are extenuating or specific circumstances that have been documented in the plans of care. In accordance with this expectation, attendant services should not be used for lawn care, snow removal, shopping, ordinary housekeeping (as this is a task that can be completed in conjunction with the housekeeping/laundry done by the individual with whom the recipient lives), and meal preparation during the times when the person with whom the recipient lives would normally prepare a meal for themselves.

The majority of these contacts must occur in customary and usual community locations where the child lives. Services provided in a home school setting must not be educational in purpose. Services furnished to an individual who is an inpatient or resident of a hospital, nursing facility, intermediate care facility for persons with mental retardation, or institution for mental disease are non-covered.

The cost of transportation of an attendant service provider to and from the participant's place of residence and other services sites or places in the community is included in the reimbursement rate paid to providers of these services.

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

Long-term Community Care Attendant Service are limits to be established by SRS within the budget allocated. Providers of Long-term Community Care Attendant Service may not overlap with service provider of Specialized Medical Care.

Exceptions to exceed the limit are subject to the approval of SRS.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Personal Service Attendant (self-directed)
Agency	Medical Service Technician (agency-directed)

**Appendix C: Participant Services**

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

Service Type: Statutory Service

Service Name: Long-term Community Care Attendant Service

**Provider Category:**

Individual

**Provider Type:**

Personal Service Attendant (self-directed)

**Provider Qualifications**

License (specify):

Certificate (specify):

Other Standard (specify):

- a. Must have a High School Diploma or equivalent;
- b. Must be at least eighteen years of age or older;
- c. Must meet participant/family's qualifications;
- d. Must reside outside of waiver recipient's home;
- e. Complete the necessary skill training needed in order care for the waiver recipient as recommended either by the parent or legal representative, and qualified medical provider;
- f. Must be a Medicaid enrolled provider authorized to provide HCBS-TA waiver service;

g. Meet the skill training documentation required by SRS.

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Kansas Health Policy Authority, SRS/DBHS/CSS and SRS Regional Field staff is responsible for ensuring the Personal Service Attendant provider met the approved standards.

**Frequency of Verification:**

At a minimum, annually or more frequently as deemed necessary by SRS Health Care Policy and SRS Regional Field Staff.

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**

**Service Name: Long-term Community Care Attendant Service**

**Provider Category:**

Agency

**Provider Type:**

Medical Service Technician (agency-directed)

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

- a. Must have a high school diploma or equivalent;
- b. Must be at least eighteen years of age or older;
- c. Must meet the agency's qualifications;
- d. Must reside outside of waiver recipient's home;
- e. Must complete training and pass certification as regulated under K.A.Rs 28-39-165 or 28-51-100 by the State of Kansas licensing agency;
- f. Must be employed by and under the direct supervision of a home health agency licensed by the Kansas Department of Health and Environment, enrolled as a Medicaid provider to provide HCBS-TA waiver services;
- g. Meet the skill training documentation required by SRS.

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Kansas Health Policy Authority, SRS/DBHS/CSS and SRS Regional Field staff is responsible for ensuring the Medical Service Technician provider met the approved standards.

**Frequency of Verification:**

At a minimum, annually or more frequently as deemed necessary by SRS/DBHS/CSS and SRS Regional Field Staff.

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

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

**Service Type:**

Statutory Service

**Service:**

Respite

**Alternate Service Title (if any):**

Medical Respite Care

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

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

**Service Definition (Scope):**

Medical Respite Care is a temporary service provided on an intermittent basis for the purpose of relieving the family of the care of a technology dependent and medically fragile person for short, specified periods of time. Respite care must be provided in the recipient's place of residence or community and has its purpose:

The meeting of nonemergency or emergency family needs; restoration or maintenance of the physical and mental well-being of the child and/or family providing supervision, companionship and personal care to the child for the specified period of time.

Providers of medical respite service is limited to a skilled nursing staff ( RN or LPN) licensed to practice in Kansas under the direct supervision of a home health agency licensed by the Kansas Department of Health and Environment.

Federal financial participation is not claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

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

A maximum of 7 days or 168 hours per calendar year will be provided.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Specialized Medical Care- Respite Care

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**  
**Service Name: Medical Respite Care**

**Provider Category:**

Agency

**Provider Type:**

Specialized Medical Care- Respite Care

**Provider Qualifications****License (specify):**

Licensed in the State of Kansas to practice in the capacity of a nurse and is under the employment of a Home Health Agency. The provider of respite care must be licensed in the following:

- Registered Nurse (RN)
- Licensed Practical Nurse (LPN)

**Certificate (specify):**

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**Other Standard (specify):**

\*All standards, certifications and licenses that are required for the specific professional field through which service is provided including but not limited to:

- professional license / certification if required;
- adherence to HCP/CSS training and professional development requirements;
- maintenance of clear background as evidenced through background checks of; KBI, APS,CPS, KSBN Registry, and Motor Vehicle screen".
- Must meet the licensing standards as regulated by Kansas Department of Health and Environment as specified in K.S.A 65-5101 through K.S.A. 65-5117
- Must be employed under an enrolled Medicaid provider authorized to provide services under the HCBS-TA Waiver.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Kansas Health Policy Authority, SRS/DBHS/CSS and SRS Regional Field staff is responsible for ensuring the Medical Respite Care provider met the approved standards.

**Frequency of Verification:**

At a minimum, annually or more frequently as deemed necessary by SRS/DBHS/CSS and SRS Regional Field Staff.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Home Modification

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

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

**Service Definition (Scope):**

For the purpose of this waiver, home modification services are defined as modifications to the participant's home. The need for home modification is an identified necessity to assist individuals in the day to day function as indicated in the individualized plans of care. The goal is to assist participants in supporting their independence, mobility and maintain their productiveness in the community.

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

The reimbursement of home modification services are limited to:

- a. Purchase a "participant transfer lift"
- b. Purchase of or installation of ramp not covered by any other resources;
- c. The widening of doorways;
- d. Modifications to bathroom facilities owned by the individual, parent or legally responsible party where participants reside;
- e. Modifications related to the approved installation of modified ramps, doorways or bathroom facilities
- f. Services shall be provided within specified local and state building codes.
- g. Modifications are made within the existing structures and must not result in addition of square footage to the existing structure.

Home Modification Services limits are set based on historical case information of other waiver services and reimbursement data demonstrates the adequacy of the limit in addressing individuals needs.

Individuals are assessed for home modification needs by the Independent Case Manager, utilizing the Medical Assistive Technology Level of Care (MATLOC) instrument. The Independent Case Manager and participant or parent/ legal guardian will obtain and propose to SRS 2 bids for the equipment or modification per policy guidelines.

To avoid any overlap of services, Home Modification Services are limited to those services not covered through regular State Plan Medicaid and which cannot be procured from other formal or informal resources (such as Vocational Rehabilitation, Rehabilitation Act of 1973, or the Educational System). HCBS-TA waiver funding is used as the funding source of last resort.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Home Modification Provider
Agency	Home Modification Provider

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**

**Service Type:** Other Service  
**Service Name:** Home Modification

**Provider Category:**

Individual

**Provider Type:**

Home Modification Provider

**Provider Qualifications****License (specify):**

Licensed contractor/DME provider

**Certificate (specify):**

	<input type="checkbox"/> <input type="checkbox"/>
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**Other Standard (specify):**

A licensed contractor/DME provider eligible to provide home modifications services as specified in this section of appendix "C" under service specification. The property must be occupied and owned by the participants or the parent or legally responsible individual where the participant resides.

All services provided must meet the local city and state building codes.

Providers of this service must meet all standards, certifications and licenses that are required for the specific field through which service is provided including but not limited to: professional license / certification if required; maintenance of clear background as evidenced through background checks of; KBI, APS, CPS, and Motor Vehicle screen.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Independent Case Managers are responsible for ensuring the Home Modification provider meets the approved standards.

**Frequency of Verification:**

At a minimum, annually or more frequent as deemed necessary by SRS/ Disability and Behavioral Health and SRS Regional Field Staff.

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**


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**Service Type: Other Service**
**Service Name: Home Modification**


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**Provider Category:**

Agency <input checked="" type="checkbox"/>
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**Provider Type:**

Home Modification Provider

**Provider Qualifications****License (specify):**

Licensed contractor/ DME provider

**Certificate (specify):**

	<input type="checkbox"/> <input type="checkbox"/>
--	--

**Other Standard (specify):**

A licensed contractor/DME provider eligible to provide home modifications services as specified in this section of appendix "C" under service specification. The property must be occupied and owned by the participants or the parent or legally responsible individual where the participant resides.

All services provided must meet the local city and state building codes.

Providers of this service must meet all standards, certifications and licenses that are required for the specific field through which service is provided including but not limited to: professional license / certification if required; maintenance of clear background as evidenced through background checks of; KBI, APS, CPS, and Motor Vehicle screen.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Independent Case Managers are responsible for ensuring the Home Modification provider meets the approved standards.

**Frequency of Verification:**

At a minimum, annually or more frequent as deemed necessary by SRS/ Disability and Behavioral Health and SRS Regional Field Staff.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Specialized Medical Care

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

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

**Service Definition (Scope):**

This service provides long-term home and community nursing support for medically fragile and technology dependent waiver recipients. The required nursing level of care is intended to provide medical support for individuals requiring ongoing daily hospital level of care in the participant's place of residence or community in lieu of hospitalization. The service is to effectively address the intensive medical needs of the participant and prevent hospitalization or the need for long-term hospitalization so that participant may choose to live in the community.

For the purpose of this waiver, providers of Specialized Nursing Care services are typically provided by a Registered Nurse (RN), or Licensed Practical Nurse (LPN) under the supervision of a Registered Nurse, trained to deliver skilled nursing services identified in the plans of care which are within the scope of the State's Nurse Practice Act. Providers of this service are trained with the medical skills necessary to care for and meet the medical needs of individuals served under the TA Waiver.

The service may be provided in all customary and usual community locations including where the individual reside and socializes.

It is the responsibility of the provider agency to ensure appropriate levels of nursing is employed and utilized to meet the specific medical needs of the participant.

Specialized Nursing Care service does not duplicate any other Medicaid State Plan Service or other services otherwise available to recipient at no cost.

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

The medical necessity of this service is subject to the nursing acuity assessment as identified in the Medical Assistive Technology Level of Care (MATLOC) instrument and the participant's plans of care.

Limitation of this service to be established by SRS based on budgetary allowance.

Providers of this service will be reimbursed for medically appropriate and necessary services relative to the level of need as identified in the plans of care (POC).

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Specialized Medical Care

**Appendix C: Participant Services**

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

Service Type: Other Service  
 Service Name: Specialized Medical Care

Provider Category:

Agency

Provider Type:

Specialized Medical Care

Provider Qualifications

License (specify):

- Registered Nurse (RN)
- Licensed Practical Nurse (LPN)

Certificate (specify):

- Hold a current license granted by the Kansas State Board of Nursing (KSBN) to practice in the capacity of a nurse in the Kansas.

Other Standard (specify):

\*All standards, certifications and licenses that are required for the specific professional field through which service is provided including but not limited to:

- professional license / certification if required;
- adherence to HCP/CSS training and professional development requirements;
- maintenance of clear background as evidenced through background checks of; KBI, APS, CPS, KSBN Registry, and Motor Vehicle screen".
- Must meet the licensing standards as regulated by Kansas Department of Health and Environment as specified in K.S.A 65-5101 through K.S.A. 65-5117
- Must be employed under an enrolled Medicaid provider authorized to provide services under the HCBS-TA Waiver.

Verification of Provider Qualifications

Entity Responsible for Verification:

Kansas Health Policy Authority, SRS/DBHS/CSS and SRS Regional Field staff is responsible for ensuring the Specialized Medical Care provider met the approved standards.

Frequency of Verification:

At a minimum, annually or more frequently as deemed necessary by SRS Health Care Policy and SRS Regional Field Staff.

**Appendix C: Participant Services**

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

- b. **Alternate Provision of Case Management Services to Waiver Participants.** When case management is not a covered waiver service, indicate how case management is furnished to waiver participants (select one):
  - Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
  - Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies

- As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). Complete item C-1-c.
- As an administrative activity. Complete item C-1-c.
- None of the above apply (i.e., case management is furnished as a waiver service)
- c. **Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

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## Appendix C: Participant Services

### C-2: General Service Specifications (1 of 3)

- a. **Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):
- No. Criminal history and/or background investigations are not required.
- Yes. Criminal history and/or background investigations are required.

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

The contractor / sub contractor and /or provider must complete a Kansas Bureau of Investigations (KBI), APS,CPS, KSBN, nurse aide registry, and motor vehicle screen upon the hiring of the following service providers:

- Independent Case Management
- Long-term Community Care Attendant
- Medical Respite
- Specialized Medical Care

The contractor / sub contractor and /or provider must provide evidence that required standards have been met or maintained at the renewal of their professional license. These standards can be reviewed by SRS Regional Field Staff at the time of their reviews and sooner if a potential problem is identified. At any time deemed appropriate by SRS, a license or certification, if applicable may be formally reviewed by SRS to determine whether the licensee continues to be in compliance with the waiver service requirements.

A provider must provide the above documentation along with qualifications to the HCBS- TA Waiver Program Manager and receive prior authorization to provide service prior to initiation of service.

- b. **Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):
- No. The State does not conduct abuse registry screening.
- Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The contractor / sub contactor and /or provider must check all individuals against the Kansas Social Rehabilitation Services (SRS) child abuse, adult abuse and nurse aide registries. SRS maintains the registries for all confirmed perpetrators.

- Independent Case Management
- Long-term Community Care Attendant
- Medical Respite
- Specialized Medical Care

The contractor / sub contactor and /or provider must provide evidence that required standards have been met or maintained at the renewal of their professional license. This standard can be reviewed by SRS Regional Field Staff at the time of their reviews and sooner if a potential problem is identified. At any time deemed appropriate by SRS, a license or certification, if applicable may be formally reviewed by SRS to determine whether the licensee continues to be in compliance with the waiver service requirements.

## Appendix C: Participant Services

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

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

- No. Home and community-based services under this waiver are not provided in facilities subject to §1616 (e) of the Act.**
- Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

## Appendix C: Participant Services

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

d. **Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

- No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

A parent may be reimbursed when providing skilled nursing level of care for waiver participants. The parent of a minor child may be paid under the Medicaid program if the parent of a minor child lives with the waiver-eligible

consumer or child, and has been determined to be a person essential to the consumer's well-being in accordance with K.A.R. 30-5-307. The parent of the minor child must also have received the training and licensing necessary to perform the nursing level that is deemed extraordinary above normal parental duties. Limitation of services and the hours of service provided by a nursing professional parent or legally responsible individuals are subject to limitations as defined in the "Professional Service Under Defined Condition" of Technology Assisted Waiver Policies and Procedure manual. Limitation of services is governed by the assessed need of the consumer based on the nursing acuity and the individual/family needs assessments. The number of service hours is limited to the assessed medical need and parent's ability to safely care for the participant in the capacity of a paid caregiver and his/her responsibility as a parent. Services greater than the assessed need of the consumer or established limits are not furnished by the waiver. The limitations services provided under "Professional Service under Defined Condition" takes into consideration the following;

- Lack of a qualified provider in remote areas of the state;
  - Lack of a qualified provider capacity who can furnish services at necessary times and places
  - It is determined in the best interest of the waiver participant due to relative's familiarity with the participant's condition and is essential to assuring the health and welfare of the participant
  - The care required provided for the participant exceeds what a parent would ordinarily be expected to provide.
  - The parent/legal guardian is a medically trained professional. The parent must possess a skilled nursing level of formal training and knowledge.
  - Parent/legal guardian holds a current LPN or RN license in the state of Kansas to practice nursing.
  - Parent/legal guardian must be employed by a Home Health Agency approved by Medicaid to provide TA waiver services, and will adhere to the policies and procedures of that agency.
  - Parent/legal guardian will only be paid for medically oriented tasks required to meet the medical needs of the child.
  - Parent/legal guardian has no prior convictions of child abuse, neglect, or exploitation of a child or an adult.
- All persons delivering services under the provision of "extraordinary care" are providing services under the direction of a Physician and is an employee of a Home Health Agency, enrolled as a Medicaid provider designated to provide HCBS-TA Waiver services.

Assurance that payments are made only for medically necessary services identified in the plans of care is provided through periodic reviews conducted by the Surveillance and Utilization Review System (SURS) unit of the state's contracted fiscal agent.

The Plan of Care includes services to be furnished, their frequency, the type and ID number of the provider who will provide each service, and the costs of each service. Payment is limited to the provision of services provided under "Professional Service under Defined Condition" guideline and the needs identified through an assessment utilizing the MATLOC instrument.

Both the Plan of Care and the claims are compared electronically through MMIS.

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

- The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

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

- Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

A relative/legal guardian may provide, whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-3 for Personal Service Attendant care. Relatives, but not a relative who is also a

responsible person or legal guardian may provide personal assistance services. Limitation of services and the hours of service provided by a relative/legal guardian are subject to the limitation if any, as established by SRS.

The Individual/ Family Needs assessment and individualized plans of care is utilized to determine if the legal guardian will be a paid provider of Personal Service Attendant care. The plan should indicate the specific type of service to be provided by the legal guardian and how it was determined that it was in the best interest of the participant that the specific service would be provided by the legal guardian.

Both the Plan of Care and the claims are compared electronically through MMIS. The Plan of Care include the service to be furnished, their frequency, the type and ID number of the provider who will provide the service, and the costs associated with providing the service.

**Other policy.**

Specify:

**f. Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Any willing and qualified provider may enroll with the State's fiscal agent as a Medicaid provider. Enrollment through the fiscal agent is a continuous open enrollment. There is a specific department called Provider Enrollment with an 800 telephone number, and enrollment packets and general enrollment information are continuously available on the Internet. The State assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services provided under the waiver. The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care.

Provider Enrollment and Data Maintenance Performance Expectations are as follows:

- a) Mail provider enrollment packets within two (2) business days of request.
- b) Process provider applications and updates within five (5) business days of receipt.
- c) Notify providers of acceptance/rejection within ten (10) business days of receipt of the application. (This notification includes information regarding the provider's program billing, NPI, and other information as the State may require.
- d) Supply provider with HCFA Common Procedure Coding System (HCPCS) code listings within five (5) business days of request.
- e) Update institutional rates on the provider master file within two (2) business days of receipt.
- f) Provide minutes of provider enrollment meetings to the State within ten (10) business days.

## **Appendix C: Participant Services**

### **C-3: Waiver Services Specifications**

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

## **Appendix C: Participant Services**

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

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

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

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

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

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

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

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

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

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

**State Participant-Centered Service Plan Title:**  
Medical Assistive Technology Plans of Care

- a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies)*:
- Registered nurse, licensed to practice in the State**
  - Licensed practical or vocational nurse, acting within the scope of practice under State law**
  - Licensed physician (M.D. or D.O)**
  - Case Manager** (qualifications specified in Appendix C-1/C-3)
  - Case Manager** (qualifications not specified in Appendix C-1/C-3).

*Specify qualifications:*

<input type="checkbox"/>	<b>Social Worker.</b> <i>Specify qualifications:</i>	
<input type="checkbox"/>	<b>Other</b> <i>Specify the individuals and their qualifications:</i>	

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

### D-1: Service Plan Development (2 of 8)

**b. Service Plan Development Safeguards. *Select one:***

- Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.
- Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

A primary safeguard in assuring participant choice is the "Referral and Service Choice" form documenting the election of waiver and service choices prior to being evaluated for the level of care determination. The documentation assures the participant's choice was not influenced, but rather by his/her own choosing.

The case management entity will carry out the following safeguards to ensure that an individual plan of care is conducted in the best interests of the individual and family;

- \*Review with the waiver participant and/or family the "Referral and Choice form;
- \*Choice is offered at least annually, regardless of current provider, or any time at the request of the participant and/or family;
- \*Choice is documented with the participant and/or family signature and place for review in the participant's case file.
- \*Present a list of service providers in order to promote individual choice;
- \*Educate the participant and/or family regarding the pros and cons of self-directed services;
- \*Discuss with participant and/or family the risk, services, frequency and duration of services;
- \*Assist the participant and/or family in developing the Plan of Care;
- \*Discuss participant rights and responsibilities available to all Medicaid recipients when the participant and /or family disagree with an adverse action such as choice of HCBS vs. institutional services, choice of provider or services, and denial, reduction, suspension or termination of services;
- \*The chosen case management entity will provide ongoing monitoring and coordination of services.

The State employs SRS Regional Field Staff. These individuals are assigned to specific SRS regional service areas around the State and are responsible for assuring that individuals receive quality

services. This is done through ongoing observation, monitoring and feedback of the services provided by the service providers.

\*The SRS Regional Field Staff, on a quarterly basis, review the services of sample waiver consumers.

\*The participant's POC and choice is monitored by SRS Regional Field Staff as a component of waiver assurance and minimum standards.

\*The participant's POC are modified as changes to eligibility, preferences and individual needs at reassessment, annually or as needed to meet the needs of the participants.

\*The annual POC is reviewed and monitored electronically.

The safeguards in place for all other Medicaid providers apply to these providers (K.A.R. 30-5-59; K.A.R. 30-5-301). Post pay reviews completed by the fiscal agent and quality assurance reviews completed by the SRS Regional field staff to monitor consumer services. In addition, Plans of Care are written for participant's needs with the participant's input and authorized by the participant. Plans of Care are intended to be cost efficient and cost effective (K.A.R. 30-5-304; K.A.R. 30-5-305).

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

### D-1: Service Plan Development (3 of 8)

- c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

When the case management entity has determined an individual likely to require the level of care provided in a hospital, the individual or his/her legal representative will be (1) informed of any feasible alternative available under the waiver, and (2) given the choice of either institutional or home and community based services, [42 CFR 441.302 (d)], and permitted to choose between them. The participant will be provided access to the following;

\* A copy of the HCBS-TA waiver Referral and Service Choice form to document the participant has been offered the freedom of choice and to offer a fair hearing

\* The HCBS-TA Waiver Participant Rights & Responsibilities which, among other rights and responsibilities, lists the right to services which are provided to persons in their category of eligibility in accordance with the Medicaid state plan, based on the availability of services and fiscal limitations.

The participant has, unless a guardian is in place, the right to determine who is included in the process, which case management entity to use, which service providers to use, and which payroll agency to use for self-directed services.

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

### D-1: Service Plan Development (4 of 8)

- d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

All applicants for HCBS-TA waiver services must undergo an assessment to determine level of care "functional eligibility" for the waiver. The primary technology and the nursing acuity portion of the Medical Assistive

Technology Level of Care (MATLOC) instrument are utilized to assess for functional eligibility. The instrument assesses the medical assistive technology device and the level of nursing care needs required by the individual.

The case management entity conducts the assessment of the individual applying for waiver services within ten (10) working days of the referral, unless a different timeframe is requested by the individual applying for services or their legal representative, if appropriate. The first four pages of the MATLOC assess the level of care eligibility for HCBS-TA waiver services. The first page assesses the medical assistive technology (ies) required by the individual. The nursing acuity level is assessed on pages two through four, it demonstrates the nursing tasks needed by the individual. The nursing acuity is weighted using a point scoring system for each applicable nursing task or care element. The nursing acuity score is combined with the technology score to achieve a comprehensive level of care determination for the applicant. The instrument assesses for eligibility based on the individual's medical technology and nursing level of care needs.

If the applicant is determined eligible for waiver services and chooses waiver services, the case management entity of choice will educate the individual or legal representative regarding the waiver process and its services. In order to coordinate services, the case management entity will refer to the "Referral and Service Choice" form in which the individual or legal representative has selected waiver services and the provider(s) of choice. The case management entity will need to complete the Individual/ Family Needs assessment and Service Delivery Plan component in order to secure information about participant needs, preferences, goals, and health status.

The MATLOC and Individual/ Family Needs assessment and Service Delivery Plan is designed to provide a comprehensive evaluation of the participant by assessing the following:

- \* Participant's medical assistive technology needs;
- \* Attendant and skill nursing level of care needs;
- \* Comprehensive evaluation of the participant's health;
- \* Communication and social needs;
- \* Participant's home and environment;
- \* Informal and formal supports;
- \* Participant's general health needs and goals;
- \* Participant's individual and family needs.

All these considerations assist the case management entity in developing and coordinating the services appropriate to meet the participant's needs. All informal supports and non-waiver services are considered in order to assure non-duplication of waiver services.

The applicant is the primary source of information. The case management entity may contact other sources such as physicians, other health care providers, or family members to obtain necessary information for the purpose of developing a comprehensive individualized POC. A request for release of information must be granted and signed by the participant or designee.

It is the responsibility of the case management entity to coordinate waiver and non-waiver services in order to address the needs of the participant.

The case management entity will review the rights and responsibilities of being a HCBS-TA waiver participant, and discuss responsibilities in monitoring services. The participant/family will need to plan with the case management entity a follow up schedule to better evaluate participant's needs, the participant shall choose the time and frequency of the follow up visits, this must be included in the participant's Plan of Care.

Case management services are ongoing and provided in the participant's place of residence or community. The reassessments are to be conducted at least every six months. The participant/designee is responsible for reporting any changes in services, or changes in the quality of services, provided. Dependent upon the frequency of the case management visits, the case management entity monitors services on an ongoing basis as well as the quality of those services.

The reassessment is to be conducted to determine continued level of care eligibility based on the established criteria as well as the following;

- \* Ensure participant's needs are met by the waiver program;
- \* Waiver services are adequate and appropriate;
- \* Waiver services are delivered to meet the health and welfare needs of the participant;

Reassessments are to be conducted more frequently if there is a change in the participant's medical, physical and

familial condition or needs. A change in the participant's residence and/or formal, as well as informal supports may result in modification to the Plan of Care and/or Individual/Family Needs assessment and Service Delivery Plan.

The Quality Assurance/Performance Improvement system established by the State also monitors the quality of services, and helps assure the health and safety of the consumer to the extent possible.

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

### D-1: Service Plan Development (5 of 8)

- e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The participant's individualized plan of care (POC) takes into account information from the MATLOC assessment which identifies the following;

- Medical technology needs
- Nursing level of care needs
- Risk factors and health indicators
- Goals and objectives tailored to address the needs of the individual
- Availability of informal supports

The POC will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service. The plan of care is the fundamental tool by which the State will ensure the health and welfare of the participant receiving services under the TA waiver.

The plan of care will be subject to periodic review and update. Reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the participant's disability and medical needs.

Each participant's plan of care is reviewed for emergency contact information during the assessment, and each family and support team will need to have a backup plan with both formal and informal providers selected. Back up plans will need to support the health and welfare needs of the participant. Examples of back up plans could include evacuation planning, notification of utility companies regarding the urgency in power restoration or maintenance due to the life sustaining device and /or backup staff in the event scheduled staff would not be available to work. The case management entity discloses to the participant, parent or legal guardian that if an individual provider of services (non-agency employee) is not available to work, he or she will bear the liability of staffing the waiver hours to meet health and welfare needs of the participant.

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

### D-1: Service Plan Development (6 of 8)

- f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The States assures that waiver participants are given informed choice of all qualified providers. It is the responsibility of the assessor or case management entity conducting the assessment to provide a list of waiver service providers to choose from. The list shall include but not limited to qualified providers of the following waiver services;

- Independent Case Management
- Specialized Medical Care
- Long-term Community Care Attendant Services
  - 1)Medical Service Technician (MST)- Agency-directed
  - 2)Personal Service Attendant (PSA)- Self-directed
- Medical Respite Care
- Home Modification Services

- Payroll agencies for self-directed services

Participants may access upon request a list of willing and qualified service providers to choose from. Participant choice is offered at a minimum annually, reassessment are conducted every six months to ensure waiver services continue to meet participant's needs.

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

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

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

The case management entity and the participant, parent or designee develops a plan of care. This plan is then submitted electronically to the Program Manager or designee at SRS/DBHS/CSS for review and approval or rejection. The case management entity will be notified electronically the approval or denial of the reviewed plan. The case management entity may begin coordination of the services to be delivered upon receipt of approval.

A paper plan of care is to be maintained in the consumer's file. This plan should be consistent with the electronic plan of care.

The Medicaid Agency monitors the following through a review of data provided by SRS that is obtained through the Quality Management Strategy:

- Access to services
- Freedom of choice
- Participants needs being met
- Safeguards that are in place to assure that the health and welfare of the participant are maintained
- Access to non-waiver services, including state plan services and informal supports
- Follow –up and remediation of identified programs

Initially, the State will continue to conduct 100% of the TA waiver participants quality reviews in order to monitor the service plans and determine if the plan is meeting the needs of the participants. It is intended the sample size of the quarterly review will decrease as the TA waiver program progress and the need for close monitoring becomes stabilized.

SRS meets on a monthly basis with the Medicaid Agency to discuss the waiver, including proposed policies and waiver amendments. On a quarterly basis, at the monthly meeting, the data obtained through the quality review process is presented to the Medicaid Agency. A portion of the data collected is obtained through a review of service plans to determine if the plan is meeting the needs of the participant while meeting the health and welfare needs of the individual.

At the monthly meetings, any issues that may have been identified during the monitoring process are reported to the Medicaid Agency. Steps taken to resolve issues are also presented at that time.

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

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

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

- Every three months or more frequently when necessary
- Every six months or more frequently when necessary
- Every twelve months or more frequently when necessary

**Other schedule**

*Specify the other schedule:*

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- i. **Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following (*check each that applies*):

- Medicaid agency**  
 **Operating agency**  
 **Case manager**  
 **Other**

*Specify:*

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

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

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

The case management entity is responsible for monitoring the implementation of the Plan of Care that was developed in partnership between the participant and family or legal representative. The case management entity will monitor the Plan of Care and participant's health and welfare needs to assure the following:

- \* Services are delivered according to the Plan of Care;
- \* Participant access to the waiver services indicated on the Plan of Care;
- \* Participant free choice of all waiver service providers;
- \* Free choice of case management representation;
- \* Documentation of participant choice to self-direct services;
- \* Services meet participant's health and welfare needs, to the extent possible;
- \* Liabilities with self-direction/agency-direction are discussed;
- \* Backup plans are in place and are effective;
- \* Participant access to non-waiver services, including State Plan and health services.

The case management entity will conduct a face to face, in person monitoring and follow-up activities to include LOC redetermination and reevaluations of the individual service delivery plan utilizing the MATLOC and Individual/Family Needs Assessment instrument at a minimum every six months and/or more frequently if necessary. The case management entity will monitor on a continuous basis to ensure the plan of care is designed to address the needs of the participant as identified in the MATLOC and Individual/Family Needs Assessment.

The Plan of Care is the fundamental tool by which the State will ensure the health and welfare of the individuals served under this waiver.

SRS/DBHS/CSS Staff approve initial and updated electronic plans of care.

The POC and choice are monitored by state quality review and / or performance improvement staff as a component of waiver assurance and minimum standards. Issues found needful of resolution are reported to the case manager for prompt follow-up and remediation of identified problems. Feedback is reported to SRS.

SRS meets on a monthly basis with the Medicaid Agency to discuss the waiver, including proposed policies and waiver amendments. In order to address follow-up and actions needed, the data obtained through the quality review process is presented to the Medicaid Agency. A portion of the data collected is obtained through a review of service

plans to determine if the plan is meeting the needs of the consumer while meeting their health and welfare needs. At the monthly meetings, any issues that may have been identified during the monitoring process are reported to the Medicaid Agency, KHPA. Steps taken to resolve issues are also presented at that time.

**b. Monitoring Safeguards. *Select one:***

- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

The State assures that each participant found eligible for the waiver will be given free choice of all qualified providers of each service included in his/her written plan of care. The assessor or Case Manager presents each participant found eligible for the waiver a list of enrolled TA waiver providers and payroll agencies from which the participant can choose for agency-directed and self-directed services. This is done after the participant is assessed for services, other formal and informal services are considered, and the Plan of Care services are developed. The fact that participants can select a different case management entity for ongoing implementation and monitoring of their Plan of Care services diminish the potential for case management entity's influence and addresses conflict of interest.

- Choice and monitoring are offered at least annually, regardless of current provider or self-direction, or at other life choice decision points, or any time at the request of the individual.
- Choice is documented on the referral and service choice form with the participant signature and place for review in the case file / individual file which is maintained by the case management entity.
- The POC and choice are monitored by state quality review and / or performance improvement staff as a component of waiver assurance and minimum standards.
- The POC is modified to meet change in needs, eligibility, or preferences, at least annually or during the re-assessment process.

The safeguards in place for all other Medicaid providers apply to these providers. Post-pay reviews completed by the fiscal agent and quality assurance reviews completed by the SRS/DBHS/CSS Regional field staff monitor participant services. In addition, Plans of Care are written for participant needs with the participant's input and authorized by the participant. Plans of Care are to be both cost efficient and cost effective (K.A.R. 30-5-304; K.A.R. 30-5-305). The participant has free choice of service providers and payroll agents.

## Appendix E: Participant Direction of Services

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

- Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

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

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

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

## Appendix E: Participant Direction of Services

- a. **Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

In this waiver, participant direction is offered in Long-term Community Care (self-directed) attendant service. The participant is offered an opportunity as a waiver recipient, or legal representative, if appropriate, the choice of assessors or case management entity to conduct the level of care eligibility assessment and reassessment for waiver eligibility. Following the assessment, if determined eligible for Long-term Community Care (self-directed) attendant services, the participant, or legal representative then chooses whether or not to self-direct his/her attendant care. If self-direction is chosen, the Case Manager will assist the participant or legal representative by reviewing the responsibilities of self-direction and the following:

- A list of payroll agencies in his/her area.
- Self-direction tool-kit resource
- The participant liabilities in self-directing before making the choice to self- direct or to agency-direct services.
- The Case Manager will assist the participant or legal representative in selecting a payroll agent.
- The participant or legal representative will need to identify and select the probable Long-term Community Care (self-directed) attendant and direct the individual to the payroll agent for enrollment.
- All Long-term Community Care (self-directed) Attendant services will be arranged for, purchased under the consumer's written authority, and paid for through the payroll agent.

Alternatively, if self-direction is not chosen, the Case Manager will provide the participant or legal representative a list of agency-directed attendant services in his/her area. The Case Manager will be responsible for coordination of Long-term Community Care (agency-directed) attendant services for the individual.

The Case Manager will facilitate and coordinate services with waiver service providers within the approved limited resources. The Case Manager will review with the waiver participant the rights and responsibilities under self-direction and provide necessary guidance for waiver participant who choose to self-direct.

Waiver participants who self-direct his/her Long-term Community Care (self-directed) attendant under the waiver are permitted to choose any qualified providers to deliver the service deemed necessary as identified in his/her Individual/Family Needs Assessment Service Delivery Plan and Plan of Care, subject to limits and approval by SRS. Providers of Long-term Community Care (self-directed) attendants may perform health maintenance activities when they are delegated by the individual/legally responsible individual, physician or a licensed professional nurse and are documented in the Plan of Care. This delegation must comply with the scope practice regulated by the State.

## Appendix E: Participant Direction of Services

### E-1: Overview (2 of 13)

- b. **Participant Direction Opportunities.** Specify the participant direction opportunities that are available in the waiver. *Select one:*

- Participant: Employer Authority.** As specified in *Appendix E-2, Item a*, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- Participant: Budget Authority.** As specified in *Appendix E-2, Item b*, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- Both Authorities.** The waiver provides for both participant direction opportunities as specified in *Appendix E-2*. Supports and protections are available for participants who exercise these authorities.

- c. **Availability of Participant Direction by Type of Living Arrangement.** *Check each that applies:*

- Participant direction opportunities are available to participants who live in their own private residence or

the home of a family member.

- Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.
- The participant direction opportunities are available to persons in the following other living arrangements

Specify these living arrangements:

**Appendix E: Participant Direction of Services**

**E-1: Overview (3 of 13)**

d. **Election of Participant Direction.** Election of participant direction is subject to the following policy (*select one*):

- Waiver is designed to support only individuals who want to direct their services.
- The waiver is designed to afford every participant (or the participants representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
- The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.

*Specify the criteria*

**Appendix E: Participant Direction of Services**

**E-1: Overview (4 of 13)**

e. **Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Participant-directed (self-directed) care is an option for Long-term Community Care (self-directed) attendant in the HCBS-TA Waiver. It allows participants in need of services to live in a less restrictive environment in their home or community to direct the services identified in the MATLOC, individual/ family needs assessment and plans of care (POC). The service has been determined by the participant and the Case Manager to be essential ADLs and IADLs. Long-term Community Care (self-directed) attendant is to be provided in accordance with the Plan of Care (POC) which has been completed by the participant and the Case Manager, and approved by SRS/DBHS/CSS approval staff.

The participant must exercise responsibility in making choices about Long-term Community Care (self-directed) attendant and understand the impact of the choices made, and assume responsibility for the results of his/her choices. By choosing self-direction, the participant assumes the responsibility of hiring, training, monitoring and terminating their attendants. The participant must also ensure that attendants' work times follow the approved Plan of Care and that all services stated on TA waiver Long-term Community Care (self-directed) attendant care worksheet

are provided.

The specific functions that must be performed by the participant, the participant's legal guardian and/or the individual designated by the participant/family to act on behalf of the participant are as follows:

- Recruit attendants and backup attendants for the Long-term Community Care (self-directed) attendant;
- Collect basic information for establishing the attendant's file with respect to the identity of the attendant (name, address, phone number, etc.) and background (past work history and any relevant training) in the form of an application for employment;
- Select attendants, assign hours within the limits of the service authorization, and refer them for payroll registration;
- Maintain continuous Long-term Community Care (self-directed) attendant coverage in accordance with the authorization for service. This includes assigning replacement attendants during vacation, sick leave or other absences of the assigned attendant;
- Dismiss the attendants when necessary, and notify the provider/payroll agent of the termination;
- Provide each attendant with orientation and training on the general duties, specific skilled tasks to be performed as delegated by participant, parents/legal guardian, physician, or nurse with the authority to delegate within the scope of practice allowed by State regulation. The training provided to the attendant is limited to serving the participant in which he/she has been trained to care for;
- Transmit information to the attendant(s) in regard to pay, time and leave schedules and times sheets;
- Maintain time sheets on each attendant working with the participant, verify hours worked, and forward them to the payroll agent;
- Notify the Case Manager of any changes in his/her medical condition, eligibility, or needs which affect the provision of services, such as hospitalizations or changes in healthcare needs;
- Notify all providers if there is a desire to discontinue the option to self-direct his/her services.

Case Manager will present the participant direction opportunities and responsibilities to the participant, or legal representative, if appropriate during the level of care for eligibility assessment. The Case Manager discusses with the participant the liability involved in making the choice to self-direction and to ensure the participant/family/legal guardian understand he/she is responsible for ensuring back up plans are in place to provide necessary care in the absence of a planned waiver service.

The option of having services covered by self-direction and/or by agency-direction is presented after the assessment, both formal and informal services are considered, the number of waiver hours determined, and before services are implemented.

Information on self-direction is also available to participants through the SRS/DBHS/CSS Regional Field Staff. Information regarding participant direction and copies of the K-PASS self-direction tool kit is available to all participants through the SRS/DBHS/CSS website.

This information is also available to prospective and ongoing participants through the HCBS-TA Waiver Policies and Procedures Manual found on the SRS website.

Self-direction information is shared with prospective participants, or their legal representatives, if appropriate, in early contact with, and during the assessment interview with, the prospective participant. The Case Manager, as well as the participant, is to monitor the services to ensure that necessary services are performed by the Long-term Community Care (self-directed) attendant. This information is continually available on the SRS website.

## Appendix E: Participant Direction of Services

### E-1: Overview (5 of 13)

- f. **Participant Direction by a Representative.** Specify the State's policy concerning the direction of waiver services by a representative (*select one*):

- The State does not provide for the direction of waiver services by a representative.
- The State provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: (*check each that applies*):

- Waiver services may be directed by a legal representative of the participant.

**Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Waiver services may be directed by an individual acting on behalf of the consumer as well as directed by a durable power of attorney for health care decisions, a guardian, or a conservator. A consumer who has been adjudicated as needing a guardian and/or conservator cannot choose to consumer-direct his/her care. The consumer's guardian and/or conservator may choose to consumer-direct the consumer's care. An adult participant's legal guardian and/or conservator cannot, however, act as the consumer's paid attendant for Long-term Community Care (self-directed) attendant care. Guardians and/or conservators are not allowed to benefit financially from their interactions with the ward and/or conservatee they represent (K.A.R. 30-5-302).

Each participant has an individual plan of care that is developed with input from the person, an identified responsible party, and person's who know and care about the participant.

In the event that a non-legal representative has been chosen by an adult participant, the support team, along with the participant will identify the roles and responsibilities of the non-legal representative and these roles and responsibilities will be documented in the individualized plan of care.

At any time the individualized plan of care is being reviewed and updated, the performance of the non-legal representative will be reviewed to assure that the person is functioning in the best interest of the participant and a determination will be made as to any needed changes or modifications to the role of the non-legal representative.

It is the role of the Case Manager to assure services are provided in a manner consistent with the plans of care.

**Appendix E: Participant Direction of Services**

**E-1: Overview (6 of 13)**

- g. **Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Long-term Community Care Attendant Service	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

**Appendix E: Participant Direction of Services**

**E-1: Overview (7 of 13)**

- h. **Financial Management Services.** Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

**Yes. Financial Management Services are furnished through a third party entity.** (Complete item E-1-i).

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

- Governmental entities**
- Private entities**

**No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.**

*Do not complete Item E-1-i.*

## **Appendix E: Participant Direction of Services**

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### **E-1: Overview (8 of 13)**

- i. Provision of Financial Management Services.** Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

**Answers provided in Appendix E-1-h indicate that you do not need to complete this section.**

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## **Appendix E: Participant Direction of Services**

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### **E-1: Overview (9 of 13)**

- j. Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

- Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

*Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:*

The case management's role is to assist the participant in exploring their option by directing the participant or their representative to the K-Pass (self-direction Tool Kit) which provides information on how to self-direct their Long-term Community Care Attendant care service. The case management entity will discuss with the participant whether self-direction is the right opportunity for the participant. Once the participant chooses to self-direct, the case management entity is responsible for providing the following to participants choosing to self-direct their services;

- Assessment, including an ongoing process to identify the participant's needs and preferred lifestyle, and the resources that are available to the individual through both formal and informal evaluation methods
- Support planning, with the participation of the individual and the individual's support network, including
  - o Developing (or assistance in developing), updating, and reviewing of the participant plan of care and any related service or support plan
  - o Building upon assessment information to assist the individual in meeting his or her needs and achieving the individual's preferred lifestyle
  - o Providing the following assistance to the participant:
    - Becoming knowledgeable about the types and availability of community services and support options
    - Receiving information regarding participant's rights and responsibilities
  - Support coordination, including the following:
    - o Arranging for and securing supports outlined in the individualize plans of care
    - o Developing and accessing of natural supports and general community support systems
    - o Pursuing means for gaining access to needed services and entitlements
  - Monitor and follow-up, including the following:
    - o ongoing activities that are necessary to ensure that the participant's plan of care is effectively implemented and follow-up of participant's care to assure that he or she is being served appropriately
    - o Report any concerns of fraud or abuse
  - Transition assistance and portability, including the planning of and arranging for services to follow the individual when the individual moves between any of the following:
    - o From hospital discharge to home and community
    - o To other State Plan or other waiver programs and services

- Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Long-term Community Care Attendant Service	<input checked="" type="checkbox"/>
Independent Case Management	<input checked="" type="checkbox"/>
Home Modification	<input checked="" type="checkbox"/>
Medical Respite Care	<input checked="" type="checkbox"/>
Specialized Medical Care	<input checked="" type="checkbox"/>

- Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

*Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:*

## Appendix E: Participant Direction of Services

### E-1: Overview (10 of 13)

**k. Independent Advocacy** *(select one).*

- No. Arrangements have not been made for independent advocacy.**
- Yes. Independent advocacy is available to participants who direct their services.**

*Describe the nature of this independent advocacy and how participants may access this advocacy:*

## Appendix E: Participant Direction of Services

### E-1: Overview (11 of 13)

- I. Voluntary Termination of Participant Direction.** Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

The participant has the opportunity as well as the ability to exercise responsibility in discontinuing to self-direct if they choose to do so. If the participant chooses to discontinue to self-direct, he/she is responsible for:

- Notify all providers as well as the payroll agent. He/she is to maintain continuous attendant care coverage;
- Give ten (10) days notice of his/her decision to the Case Manager in order to allow for the coordination of services through an agency.

The duties of the Case Manager are to:

- Explore other service options and complete a new Referral and Service Choice form with the participant;
- Advocate for the participant by locating and coordinating services with provider agencies in order to meet the participant's needs within the available resources.

**Appendix E: Participant Direction of Services**

**E-1: Overview (12 of 13)**

- m. Involuntary Termination of Participant Direction.** Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provide-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

The Case Manager may, if appropriate discontinue the participant's choice to self-direct Personal Service Attendant (PSA) care when, in the Case Manager's professional judgment through observation and documentation, it is not in the best interest of the participant to self-direct services. The Case Manager and qualified Medical provider must concur that the following conditions will be compromised if the participant chooses to self-direct:

- 1) The health and welfare needs of the participant are not being met based on documented observations of the Case Manager and SRS Quality Assurance staff, or confirmation by APS, and all training methods have been exhausted;
- 2) The PSA is not providing the services as outlined on the PSA care worksheet, and the situation cannot be remedied;
- 3) The participant is falsifying records resulting in claims for services not rendered.

When an involuntary termination occurs, the Case Manager will apply safeguards to assure participant's health and welfare remains intact and ensure continuity of care by offering the participant or family a choice of provider-managed services as an alternative. If the participant chooses the alternative provider managed services, the Case Manager will assess the participant's needs and coordinate services according to the individual's health and safety needs.

**Appendix E: Participant Direction of Services**

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

- n. Goals for Participant Direction.** In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

Waiver Year	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority	
	Number of Participants	Number of Participants	
Year 1	85		
Year 2	86		
Year 3	86		
Year 4 (renewal only)	88		
Year 5 (renewal only)	90		

**Appendix E: Participant Direction of Services**

**E-2: Opportunities for Participant Direction (1 of 6)**

**a. Participant - Employer Authority** Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

**i. Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both:*

- Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

Participants partner with payroll agencies or licensed home health agencies as their co-employer for the workers who provide waiver services. The agencies perform necessary payroll and human resource functions. The supports necessary for consumers to conduct employer-related functions are available through the payroll agent or licensed home health agencies enrolled as Medicaid payroll agency providers for the services that are "self-directed" by the participant.

Payroll agencies will hold a contractual agreement with the Medicaid Fiscal Agent for Kansas Healthcare Policy Authority (KHPA).

- Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-Approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

**ii. Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

- Recruit staff**  
 **Refer staff to agency for hiring (co-employer)**  
 **Select staff from worker registry**  
 **Hire staff common law employer**  
 **Verify staff qualifications**  
 **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

The payroll agencies or licensed home health agencies providing payroll and human resource functions will assume the cost of criminal history and/or background investigations.

- Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**  
 **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**  
 **Determine staff wages and benefits subject to State limits**  
 **Schedule staff**  
 **Orient and instruct staff in duties**  
 **Supervise staff**  
 **Evaluate staff performance**  
 **Verify time worked by staff and approve time sheets**  
 **Discharge staff (common law employer)**  
 **Discharge staff from providing services (co-employer)**  
 **Other**

Specify:

[Empty text box]

**Appendix E: Participant Direction of Services**

**E-2: Opportunities for Participant-Direction (2 of 6)**

b. **Participant - Budget Authority** Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. **Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

- Reallocate funds among services included in the budget
- Determine the amount paid for services within the State's established limits
- Substitute service providers
- Schedule the provision of services
- Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3
- Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3
- Identify service providers and refer for provider enrollment
- Authorize payment for waiver goods and services
- Review and approve provider invoices for services rendered
- Other

Specify:

[Empty text box]

**Appendix E: Participant Direction of Services**

**E-2: Opportunities for Participant-Direction (3 of 6)**

b. **Participant - Budget Authority**

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

ii. **Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

[Empty text box]

**Appendix E: Participant Direction of Services****E-2: Opportunities for Participant-Direction (4 of 6)****b. Participant - Budget Authority**

**Answers provided in Appendix E-1-b indicate that you do not need to complete this section.**

- iii. **Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

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**Appendix E: Participant Direction of Services****E-2: Opportunities for Participant-Direction (5 of 6)****b. Participant - Budget Authority**

**Answers provided in Appendix E-1-b indicate that you do not need to complete this section.**

- iv. **Participant Exercise of Budget Flexibility.** *Select one:*

- Modifications to the participant directed budget must be preceded by a change in the service plan.
- The participant has the authority to modify the services included in the participant directed budget without prior approval.

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

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**Appendix E: Participant Direction of Services****E-2: Opportunities for Participant-Direction (6 of 6)****b. Participant - Budget Authority**

**Answers provided in Appendix E-1-b indicate that you do not need to complete this section.**

- v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

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## Appendix F: Participant Rights

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### Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

**Procedures for Offering Opportunity to Request a Fair Hearing.** Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The participant/ parent or legally responsible representative are informed of the participant's rights and responsibilities verbally and in writing by the case management entity chosen by the participant/parent or legally responsible representative to complete the initial assessment and ongoing assessment. This communication is typically done at the first meeting and repeated as necessary.

Participants may exercise his/her right to a hearing before a hearing officer if issues remain unresolved and the request for a hearing is submitted in writing within 30 days of receiving a notice of action with the following;

- 1) Denial of waiver services
- 2) Indicative of opportunity for choice is absent
- 3) Denial of opportunity for choice of service providers
- 4) Services has been reduced or terminated
- 5) Denied the choice of home and community-based services as an alternative to the institutional care
- 6) An adverse action resulting in changes to the receipt of waiver benefits and its services

The information on participant's Rights and Responsibilities and the address of the Office of Administrative Hearings are clearly outlined on the back of Notices of Action.

The Case Manager chosen by the participant to manage his/her services will explain the hearing procedure and provide the necessary forms to the participant. The participant may have legal counsel or other representation at the hearing. If a request for a fair hearing is received prior to the effective date of action, waiver services may continue at the current level pending a decision; however, any overpayment from a continuation may be recovered if the decision is not in the participant's favor. If the participant is dissatisfied with the results of the fair hearing, the participant may request a review of the decision by the state appeals committee, (K.S.A. 75-3306; K.A.R.30-7-75)

Notices of Action for adverse action are sent to the participant by the Case Manager coordinating his/her waiver services. The participant is provided the original copy. Copies of completed Notices of Action related to any adverse action are kept in the participant's case file. Participant's Rights and Responsibilities (including the opportunity for Fair Hearing) are reviewed verbally with the participant by his/her waiver service Case Manager are printed on the back of the participant's Referral and Service Choice Form and the Notice of Action.

## Appendix F: Participant-Rights

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### Appendix F-2: Additional Dispute Resolution Process

- a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

No. This Appendix does not apply

Yes. The State operates an additional dispute resolution process

- b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including

the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

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## Appendix F: Participant-Rights

### Appendix F-3: State Grievance/Complaint System

**a. Operation of Grievance/Complaint System. *Select one:***

**No. This Appendix does not apply**

**Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

**b. Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

The Medicaid agency employs the fiscal agent to operate the consumer complaint and grievance system.

**c. Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Medical Assistance Customer Service Center (MACSC) at the fiscal agent is open to any complaint, concern, or grievance a participant has. MACSC staff log and track all contacts, whether received by phone, email or letter. Grievances may be elevated to the MACSC supervisor if the Customer Service Representative (CSR) cannot resolve. Those grievances which require extensive research or quality of care issues are referred to the Quality Assurance Team (QAT) for resolution.

Grievances handled within MACSC are normally resolved within 5 working days. Those grievances which are referred to QAT are resolved within 30 days. QAT must have the KHPA program manager's approval to extend the resolution time of a grievance beyond 30 days. QAT must also contact the grievant within 4 working days of receipt of a grievance.

QAT trends grievances on a monthly basis. Criterion for further research is based on number of grievances per provider in a specific time frame.

The case Manager will inform the participant about the Complaint and Grievance process. Participants are educated that lodging a complaint and/or grievance is not a pre-requisite or substitute for a Fair Hearing and is a separate activity from a Fair Hearing.

## Appendix G: Participant Safeguards

### Appendix G-1: Response to Critical Events or Incidents

**a. State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The state provides for the reporting and investigation of the following major and serious incidents:

- Article 15, Kansas Code for Care of Children defines:

- (a) "Child in need of care" means a person less than 18 years of age who:

- (1) Is without adequate parental care, control or subsistence and the condition is not due solely to the lack of financial means of the child's parents or other custodian;
  - (2) Is without the care or control necessary for the child's physical, mental or emotional health;
  - (3) Has been physically, mentally or emotionally abused or neglected or sexually abused;
  - (4) Has been placed for care or adoption in violation of law;
  - (5) Has been abandoned or does not have a known living parent;
  - (6) Is not attending school as required by K.S.A. 72-977 or 72-1111, and amendments thereto;
  - (7) Except in the case a violation of K.S.A. 41-727, subsection (j) of K.S.A. 74-8810 or subsection (m) or (n) of K.S.A. 79-3321, and amendments thereto, does an act which, when committed by a person under 18 years of age, is prohibited by state law, city ordinance or county resolution but which is not prohibited when done by an adult;
  - (8) While less than 10 years of age, commits any act which if done by an adult would constitute the commission of a felony or misdemeanor as defined by K.S.A. 21-3105 and amendments thereto;
  - (9) Is willfully and voluntarily absent from the child's home without the consent of the child's parent or other custodian;
  - (10) Is willfully and voluntarily absent at least a second time from a court ordered or designated placement, or a placement pursuant to court order, if the absence is without the consent of the person with whom the child is placed or, if the child is placed in a facility, without the consent of the person in charge of such facility or such person's designee;
  - (11) Has been residing in the same residence with a sibling or another person under 18 years of age, who has been physically, mentally or emotionally abused or neglected, or sexually abused; or
  - (12) While less than 10 years of age commits the offense defined in K.S.A. 21-4204a and amendments thereto.
- (b) "Physical, mental or emotional abuse" means the infliction of physical, mental or emotional injury or the causing of deterioration of a child and may include, but shall not be limited to maltreatment or exploiting a child to the extent that the child's health or emotional well-being is endangered.
- (c) "Sexual abuse" means any act committed with a child which is described in article 35, chapter 21 of the Kansas Statutes Annotated and those acts described in K.S.A. 21-3602 or 21-3603, and amendments thereto.

• Kansas statute (K.S.A. 3-1431), Reporting of certain abuse or neglect of children; persons reporting; reports, made to whom; penalties for failure to report or interference with making a report. (a) When any of the following persons has reason to suspect that a child has been injured as a result of physical, mental, or emotional abuse or neglect or sexual abuse, the person shall report the matter promptly as provided in subsection (c) or (e): Person licensed to practice the healing arts or dentistry; persons licensed to practice optometry; persons engaged in postgraduate training programs approved by the state board of healing arts; licensed psychologists; licensed masters level psychologists; licensed clinical psychotherapists; licensed professional or practical nurses examining attending or treating a child under the age of 18; teachers, school administrators or other employees of a school which the child is attending; chief administrative officers of medical care facilities; licensed marriage and family therapists; licensed clinical marriage and family therapists; licensed professional counselors; registered alcohol and drug abuse counselors; person licensed by the secretary of health and environment to provide child care services or the employees of persons licensed at the place where the child care services are being provided to the child; licensed social workers; firefighters; emergency medical services personnel; mediators appointed under K.S. A 23-602 and amendments thereto; juvenile intake and assessment workers; and law enforcement officers.

• The State of Kansas requires reporting of any suspected Abuse, Neglect, Exploitation or Fiduciary Abuse to SRS for review and follow-up within a reasonable time frame. Based on the age of the child, nature of the allegation, continued access of the perpetrator to the child, and other factors, department personnel establish the maximum response time for the report. If the report alleges that a child is in immediate, serious, physical danger, the SRS case work must take immediate action and/or request law enforcement assistance. If the report alleges that a child is not in immediate, serious, physical danger, but the report alleges critical neglect or physical/sexual abuse, SRS must respond within 72 hours. If the report alleges that a child is not in immediate, serious, physical danger and the report does not allege physical or sexual abuse or neglect, SRS must respond within 20 working days.

• Reporters can call the Kansas Protection Report Center in-state toll free at 1-800-922-5330. Telephone lines are staffed in the report center 24 hours a day, including holidays. In the event of an emergency, a report can be made to local law enforcement or 911.

The report may be made orally and shall be followed by a written report if requested. When the suspicion is the result of medical examination or treatment of a child by a member of the staff of a medical care facility or similar institution, that the staff member shall immediately notify the superintendent, manager or other person in charge of the institution who shall make a written report forthwith. Every written report shall contain if known, the name s and addresses of the child and the child's parents or other persons responsible for the child's care, the child's age, the nature and extent of the child's injury (including any evidence of previous injuries) and any other information that the maker of the report believes might be helpful in establishing the cause of the injuries and the identity of the

persons responsible for the injuries.(b) Any other person who has reason to suspect that a child has been injured as a result of physical, mental or emotional abuse or neglect or sexual abuse may report the matter as provided in subsection (c) or (e). (c) Except as provided by subsection (e), reports made pursuant to this section shall be made to the state department of social and rehabilitation services. When the department is not open for business, the reports shall be made to the appropriate law enforcement agency. On the next day that the state department of social and rehabilitation services is open for business, the law enforcement agency shall report to the department any report received and any investigation initiated pursuant to subsection (a) of K.S.A. 38-1524 and amendments thereto. The reports may be made orally or on request of the department in writing. (d) Any person who is required by this section to report an injury to a child and who knows of the death of a child shall notify immediately the coroner as provided by K.S.A.22a-242 and amendments thereto. (e) Reports of child abuse or neglect occurring in an institution operated by the secretary of social and rehabilitation services or the commissioner of juvenile justice shall be made to the attorney general. All other reports of child abuse or neglect by persons employed by or of children of persons employed by the state department of social and rehabilitation services or the juvenile justice authority shall be made to the appropriate law enforcement agency. (f) Willful and knowing failure to make a report required by this section is a class B misdemeanor. (g) Preventing or interfering with, the intent to prevent, the making of a report required by the section is a class B misdemeanor.

- b. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

- The State of Kansas has developed approved education and training in reporting Child Abuse, neglect and exploitation which is accessible through the following:

<http://www.srskansas.org/CFS/Child%20Abuse%20Reprting%20Guide.pdf>

Reporters can call the Kansas Protection Report Center in-state toll free at 1-800-922-5330.

Telephone lines are staffed in the report center 24 hours a day, including holidays. In the event of an emergency, a report can be made to local law enforcement or 911.

- Any licensed or non-licensed provider is responsible for the delivery, oversight and management of programmatic systems to ensure any agent, person, parent, guardian, and support network person have appropriate contact information for SRS Child Protective Services. SRS Division of Health Care Policy / Community Supports and Services (HCP/CSS) ensure compliance.

- The provider is responsible for informing and educating the above parties by offering, at least annual, training with regard to freedom from and reporting abuse, neglect and exploitation; and individual rights and responsibilities including effective ways to exercise those rights.

- c. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

- The entity that receives reports of each type of critical event or incident.  
Kansas Department of Social and Rehabilitative Services.

- All allegations of abuse, neglect, or exploitation are received by an intake manager at the SRS Regional Office. It is the responsibility of the Intake Manager at the SRS Regional Office to establish if a report of abuse, neglect, or exploitation merits investigation. An established screening process is utilized to determine merit. If the report indicates criminal activity, local law enforcement is notified immediately.

The screening process utilized by Child Protective Services includes 'Factors to consider in screening and response determination'. Factors the screener considers include, but are not limited to:

- child's age
- presence of any visible injury
- location of any injury
- frequency of incidents
- child's medical or physical disability
- child's ability to care for and protect self
- past history of child, care giver & alleged perpetrator
- other's ability to protect
- alleged perpetrator's access to the child

- physical/mental conditions of care giver and child
- status of law enforcement involvement
- circumstances surrounding the event/incident
- care giver's explanation of injury
- recency, frequency and duration of incidents
- time of year / weather

• The State of Kansas requires reporting of any suspected Abuse, Neglect, Exploitation or Fiduciary Abuse of a child to SRS for review and follow-up. SRS-Child Protective Services investigates all allegations of child abuse, neglect, or exploitation per their established protocol and regulations.

Based on the age of the child, nature of the allegation, continued access of the perpetrator to the child, and other factors, SRS personnel establish the maximum response time for the report. If the report alleges that a child is in immediate, serious, physical danger, the SRS case worker must take immediate action and/or request law enforcement assistance. If the report alleges that a child is not in immediate, serious, physical danger, but the report alleges critical neglect or physical/ sexual abuse, SRS must respond within 72 hours. If the report alleges that a child is not in immediate, serious, physical danger and the report does not allege physical or sexual abuse or neglect, SRS must respond within 20 working days. By policy, Children and Family Services (CFS) is required to make a case finding in 25 working days from case assignment.

• The process and timeframes for informing the participant including the participant (or the participant's family or legal representative as appropriate) and other relevant parties (e.g., the waiver providers, licensing and regulatory authorities, the waiver operating agency) of the investigation results.

The 2540 Notice of Department Finding for family reports is CFS 2012. The Notice of Department Finding for facility reports is CFS 2013. The Notice of Department Finding informs pertinent persons who have a need to know of the outcome of an investigation of child abuse/neglect. The Notice of Department Finding also provides persons information regarding the appeal process. The following persons must receive a notice:

- The parents of the child who was alleged to have maltreated
  - The alleged perpetrator
  - Child, as applicable if the child lives separate from the family
  - Contractor providing services to the family if the family is receiving services from a CFS contract
  - The director of the facility or the child placing agency of a foster home if abuse occurred in a facility or foster home
  - Kansas Department of Health and Environment if abuse occurred in a facility or a foster home
- The Notice of Department Finding shall be mailed on the same day, or the next working day, as the case finding decision, the date on the Case Finding CFS-2011. The Notice of Department Finding shall be mailed on the same day, or the next working day, as the case finding decision, the date on the Case Finding CFS-2011.

KEESM [12360] allows for joint investigations with SRS licensed facilities per the option of the SRS Service Center and the facility. Joint investigations require a Memorandum of Agreement between the SRS Service Center and the facility which must be approved by the SRS Central Office APS Attorney. Additionally, the KEESM manual [12230] requires copies of facility based reports be sent to the HCP/CSS SRS Regional Field Staff.

d. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

- SRS Child Protective Services is responsible for overseeing and investigating the reporting of all critical incidents and events.
- Child Protective Services maintains a data base of all critical incidents and events and makes available the contents of the data base to the SRS Health Care Authority.
- Oversight for compliance and assurance of regulatory standards and statute is conducted by the HCP/CSS SRS Regional Field Staff. HCP/CSS Regional Field Staff are responsible for providing on-going, on-site, and in-person monitoring, and assuring preventative action is provided by the service provider for the protection of children.

The KQMS is a two-prong approach utilizing identification minimum standard compliance and assurance of corrective action to address systematic weaknesses while simultaneously utilizing the data to identify best practices to promote participant independence, productivity, community inclusion and opportunities for systems improvement to promote participant quality of life.

Data gathered by HCP/CSS Regional Staff during the Quality Survey Process is provided quarterly to the HCP/CSS Performance Improvement Review Committee [Chaired by the Performance Improvement Program Manager / staffed by PI Staff statewide] for evaluation and trending to identify areas for improvement. Upon completion of identified areas of improvement this information is compiled into an executive report (quarterly and annually) which is

submitted to the Performance Improvement Executive Committee [Chaired by the Assistant Director HCP/CSS / staffed by Waiver Program Managers, QA Program Manager and PI Program Manager]. The Performance Improvement Executive Committee generates corrective action planning and improvement planning which is submitted to the Director of HCP/CSS of Medicaid Operating Agency for review and approval/denial and sent to the Kansas Health Policy Authority (KPHA) via the KPHA Long Term Care Committee for review by the State Medicaid Agency (SSMA). The approval/denial from the Director of HCP/CSS would be returned to the Performance Improvement Executive Committee for corrective action or planning for implementation of improvement.

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

SRS/DBHS/CSS is responsible for oversight of critical events/incidents, unauthorized use of restraints/restrictive procedures, and oversight and follow-up of appropriate medication management in accordance with Kansas regulatory and statutory requirements. Oversight of regulatory standards and statute is conducted by SRS/DBHS/CSS Regional field staff.

SRS/DBHS/CSS and SRS Child Protective Services (CPS) meet on a quarterly basis to develop evidence-based decisions based on data trending (developed by SRS/DBHS/CSS) and identify opportunities for Provider improvement and/or training.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

a. **Use of Restraints or Seclusion.** *(Select one):*

- The State does not permit or prohibits the use of restraints or seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

- SRS is responsible for overseeing any inappropriate use of restrictive procedures and ensuring the compliance with state operating and regulatory standards.
- SRS Child Protective Services is responsible for overseeing and investigating the reporting of all critical incidents and events.
- Child Protective Services maintains a data base of all critical incidents and events and makes available the contents of the data base to the SRS Health Care Authority.
- Oversight for compliance and assurance of regulatory standards and statute is conducted by the HCP/CSS SRS Regional Field Staff. HCP/CSS Regional Field Staff are responsible for providing on-going, on-site, and in-person monitoring, and assuring preventative action is provided by the service provider for the protection of children.

- The use of restraints or seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.

- i. **Safeguards Concerning the Use of Restraints or Seclusion.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

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## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

**b. Use of Restrictive Interventions. (Select one):**

- The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

- SRS is responsible for overseeing any inappropriate use of restrictive procedures and ensuring the compliance with state operating and regulatory standards.
- SRS Child Protective Services is responsible for overseeing and investigating the reporting of all critical incidents and events.
- Child Protective Services maintains a data base of all critical incidents and events and makes available the contents of the data base to the SRS Health Care Authority.
- Oversight for compliance and assurance of regulatory standards and statute is conducted by the HCP/CSS SRS Regional Field Staff. HCP/CSS Regional Field Staff are responsible for providing on-going, on-site, and in-person monitoring, and assuring preventative action is provided by the service provider for the protection of children.

- The use of restrictive interventions is permitted during the course of the delivery of waiver services**

Complete Items G-2-b-i and G-2-b-ii.

- i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

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- ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

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## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (1 of 2)

*This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.*

**a. Applicability. Select one:**

- No. This Appendix is not applicable (do not complete the remaining items)**

**Yes. This Appendix applies** *(complete the remaining items)*

**b. Medication Management and Follow-Up**

**i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

**ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

**Appendix G: Participant Safeguards**

**Appendix G-3: Medication Management and Administration (2 of 2)**

**c. Medication Administration by Waiver Providers**

Answers provided in G-3-a indicate you do not need to complete this section

**i. Provider Administration of Medications.** *Select one:*

**Not applicable.** *(do not complete the remaining items)*

**Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

**ii. State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**iii. Medication Error Reporting.** *Select one of the following:*

**Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**  
*Complete the following three items: .*

(a) Specify State agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record*:

(c) Specify the types of medication errors that providers must *report* to the State:

- Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

- iv. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

## Appendix H: Quality Management Strategy (1 of 2)

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

- Quality 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.

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).

In the QMS, a state spells out:

- The evidence based *discovery* activities that will be conducted for each of the six major waiver assurances;
- The *remediation* processes followed when problems are identified in the implementation of each of the assurances;
- The *system improvement* processes followed in response to aggregated, analyzed information collected on each of the

- assurances;
- The correspondent *roles/responsibilities* of those conducting discovery activities, assessing, remediating and improving system functions around the assurances; and
- The process that the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

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.

## Appendix H: Quality Management Strategy (2 of 2)

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### Attachment #1

#### The Quality Management Strategy for the waiver is:

The Kansas quality improvement strategy is designed to address the waiver assurances and their component elements, it includes references to the other parts of the application that pertain to each assurance. The strategy for each assurances are as follows:

#### KANSAS QUALITY IMPROVEMENT STRATEGY - Technology Assisted HCBS Waiver

##### a. LEVEL OF CARE (LOC) DETERMINATION

a.i. sub-assurance (1) An evaluation for level of care is provided to all applicants for whom there is reasonable indication that services may be needed in the future.

Performance Measure - Performance Standard = 100%; Measure = total number of persons eligible to receive LOC determination assessment VS actual number of persons who received LOC determination assessment.

##### Data Source

Medical Assistive Technology Level of Care (MATLOC) assessment instrument

Per Quality Assurance Survey Document:

I.a Date last eligibility assessment was completed.

V.IIIc Is there evidence that initial eligibility was completed?

##### b.i. Methods for Remediation / fixing Individual Problems

Individuals not meeting Level of Care criteria for eligibility will be transitioned to other waiver services or community resources within 45 days from the date of waiver ineligibility. Independent Case Management will be responsible for referring and facilitating access to alternative resources and services to meet the needs of the individual and responsible for informing individuals deemed ineligible for waiver services the rights appeal and decision and request for fair hearing.

##### a.ii. Description

Participants will receive an initial assessment, a reassessment and an annual recertification for continued level of care eligibility determination using a standardized Medical Assistive Technology Level of Care (MATLOC) assessment instrument. Reassessment for waiver services is completed every six months and recertified annually.

The Kansas Quality Improvement Strategy includes the utilization of "on-site" and in-person interviews. Interviews are conducted by Regional State Staff persons, and in the homes of the individuals receiving services, with the consumer of the services present. The interview / QA tool completion is completed annually for 100% of the TA Waiver

population. 25% of the persons served are reviewed each quarter. The Quality Survey Process includes assurance of:

- eligibility
- services and supports based on need and choice of the participant and the participant's family
- changes in eligibility and preferences

These choices are documented on:

- HCBS – Technology Assisted Waiver Referral and Service Choice form and;
- Consumer Rights and Responsibilities form with the consumer / guardian signature and placed for review in the case file / individual file and reviewed during the Quality Survey Process.

CSS monitors state staff performance to ensure initial Level of Care eligibility and assessment through quarterly Regional Field Staff Quality Activity Reporting.

#### a. LEVEL OF CARE (LOC) DETERMINATION

a.i. sub-assurance (2) The level of care of enrolled participants is reevaluated at least annually or as specified in its approved waiver.

Performance Measure - Performance Standard =100%; Measure = total number of enrolled participants eligible to receive LOC determination re-assessment VS actual number of persons who received LOC determination re-assessment during current service year.

Data Source

Medical Assistive Technology Level of Care (MATLOC) assessment instrument

Per Quality Assurance Survey Document:

VIII.d. Is there evidence that on-going eligibility / assessment was completed in the past 12 months?

a.ii. Description

Participants will receive an initial assessment, a reassessment and an annual recertification for continued level of care eligibility determination using a standardized Medical Assistive Technology Level of Care (MATLOC) assessment instrument. Reassessment for waiver services is completed every six months and recertified annually.

The Kansas Quality Improvement Strategy includes the utilization of "on-site" and in-person interviews. Interviews are conducted by Regional State Staff persons, and in the homes of the individuals receiving services, with the consumer of the services present. The interview / QA tool completion is completed annually for 100% of the TA Waiver population. 25% of the persons served are reviewed each quarter. The Quality Survey Process includes assurance of:

- annual reevaluation
- services and supports based on need and choice of the participant and the participant's family
- changes in eligibility and preferences

#### a. LEVEL OF CARE (LOC) DETERMINATION

a.i. sub-assurance (3) The process and instruments described in the approved waiver are applied appropriately and according in the approved description to determine participant level of care.

Performance Measure -

Performance Standard =100%; Measure = total number of enrolled participants eligible to receive TA Waiver Services VS actual number of persons who continue to meet eligibility criteria during current service year.

Performance Standard =100%; Measure = total number of enrolled participants required to receive LOC determination reassessment VS actual number of persons for whom the approved assessment tool was utilized to determine accurate LOC reassessment during current service year.

Performance Standard =100%; Measure = total number of enrolled participants required to receive LOC determination reassessment VS actual number of persons for whom the approved assessor conducted the LOC reassessment during current service year.

#### Data Source

Medical Assistive Technology Level of Care (MATLOC) assessment instrument

Per Quality Assurance Survey Document:

VIII.e Is there evidence that the child continues to meet eligibility criteria?

#### a.ii. Description

Participants will receive an initial assessment, a reassessment and an annual recertification for continued level of care eligibility determination using a standardized Medical Assistive Technology Level of Care (MATLOC) assessment instrument. Reassessment for waiver services is completed every six months and recertified annually.

Provider enrollment contracts between the operating agency, Kansas SRS/DBHS/CSS, and Independent Case Management providers whereby Independent Case Management Providers contract to:

- Qualify to conduct and perform the level of care eligibility assessment
- Coordinate access to services and monitor service provisions as defined by Kansas SRS/DBHS/CSS

The Kansas Quality Improvement Strategy includes the utilization of “on-site” and in-person interviews. Interviews are conducted by Regional State Staff persons, and in the homes of the individuals receiving services, with the consumer of the services present. The interview / QA tool completion is completed annually for 100% of the TA Waiver population. 25% of the persons served are reviewed each quarter. The Quality Survey Process includes assurance of:

- eligibility
- annual reevaluation
- services and supports based on need and choice of the participant and the participant’s family
- changes in eligibility and preferences

#### a. SERVICE PLANS

a.i. sub-assurance (1) Service plans address all participant’s assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means.

#### Performance Measure

Performance Standard =100%; Measure = total number of enrolled participants VS actual number of participants with service plans that address assessed functional needs during current service year.

Performance Standard =100%; Measure = total number of enrolled participants VS actual number of participants with service plans that address health and safety risk factors during current service year.

Performance Standard =100%; Measure = total number of enrolled participants VS actual number of participants with service plans that includes personal goals during current service year.

#### Data Source

Per Quality Assurance Survey [Quality Improvement Strategy Tool – completed “on-site” and “in-person”] Document:

I.a Do you have access to needed health care providers in your (person/family) receiving service local community?

I.d Does your family have an evacuation plan for 'severe/emergencies? (Life Threatening)

I.d.i In the reviewer's opinion, can the family follow the evacuation plan?

I.d.ii Are the child's primary safety, health, and medical needs consistently identified and met?

III.d Is the family involved in the development of goals?

IV.a Do you have the opportunity to express your child's technology needs and are your opportunities to communicate effective?

IV.b Does your Case Manager support you, listen to you, and assist you in developing resources for your child and his/her technology needs?

V.b Is your Case Manger available when you need him/her? (scored responses include - Always Avail, Usually Avail, Within One Hour, Returned That Day, Returned One Week)

V.c I rate my services provided by my services provided by my Case Manager as: (scored responses include - Always Avail, Usually Avail, Within One Hour, Returned That Day, Returned One Week)

V.d Does your Case Manger help you locate and access the services you want?

V.e Are there services that you requested, but did not receive?

V.g Are there natural/informal supports (unpaid) such as family, friends, church or civic groups, involved in the person's life?

VII.a Has your Case Manger talked with you about your plans when you no longer receive HCBS/TA Waiver services?

a.ii. Description

The Quality Survey Process includes assurance of:

- access to needed health care providers
- child's primary safety, health, and medical needs
- services and supports based on need and choice of the participant and the participant's family
- changes in eligibility and preferences
- availability of and participant satisfaction with waiver services
- availability of natural/informal (unpaid) supports

a. SERVICE PLANS

a.i. sub-assurance (2) The state monitors service plan development in accordance with its policies and procedures.

Performance Measure

Performance Standard =100%; Measure = total number of enrolled participants VS actual number of participants with service plans developed in accordance with approved policies and procedures.

Data Source

Per Quality Assurance Survey [Quality Improvement Strategy Tool – completed "on-site" and "in-person"] Document:

VII.a Has your Case Manager talked with you about your plans when you no longer receive HCBS/TA Waiver services?

VII.b Are you using natural supports in the community?

VIII.a Is there evidence that needed training and support for family members while the child is on the HCBS/TA Waiver services?

VIII.b Is there evidence of appropriate training and support for family members to assist the child and family when the person transitions off the HCBS/TA Waiver?

VIII.g Is there evidence that the plan of care addresses all participant needs (including health and safety risk factors)?

#### a.ii. Description

The Kansas Quality Improvement Strategy includes the utilization of "on-site" and in-person interviews. Interviews are conducted by Regional State Staff persons, and in the homes of the individuals receiving services, with the consumer of the services present. The interview / QA tool completion is completed annually for 100% of the TA Waiver population. 25% of the persons served are reviewed each quarter. The Quality Survey Process includes assurance of:

- Current service planning based on need, choice, and lifestyle preferences of the participant and the participant's family
- participant's family assists in the development of all service planning
- access to needed health care providers
- service planning to identify primary safety, health, and medical needs
- availability of necessary risk management assessments, backup planning, and/or transition planning
- service planning is developed, implemented, and revised at least annually or more frequently, as needed
- availability of and participant satisfaction with waiver services
- availability of and planning for natural/informal (unpaid) supports

#### a. SERVICE PLANS

a.i. sub-assurance (3) Service plans are updated / revised at least annually or when warranted by changes in the waiver participant's needs.

#### Performance Measure

Performance Standard =100%; Measure = total number of enrolled participants VS actual number of participants with service plans which are updated/revised annually or as warranted by participant's needs / preferred lifestyle during current service year.

#### Data Source

Per Quality Assurance Survey [Quality Improvement Strategy Tool – completed "on-site" and "in-person"] Document:

I.d.iv Is the Case Manager aware of this (primary safety, health, and medical needs NOT consistently met) and have they taken appropriate steps?

VI.c Are there things you would like to know regarding available services, community supports, but have not been given the opportunity.

VIII.d Is there evidence that on-going eligibility / assessment was completed in the past 12 months?

VIII.g Is there evidence that the plan of care addresses all participant needs (including health and safety risk factors)?

## a.ii. Description

The Kansas Quality Improvement Strategy includes the utilization of “on-site” and in-person interviews. Interviews are conducted by Regional State Staff persons, and in the homes of the individuals receiving services, with the consumer of the services present. The interview / QA tool completion is completed annually for 100% of the TA Waiver population. 25% of the persons served are reviewed each quarter. The Quality Survey Process includes assurance of:

- current service planning based on need, choice, and lifestyle preferences of the participant and the participant’s family
- participant’s family assists in the development of all service planning
- access to needed health care providers
- service planning to identify primary safety, health, and medical needs
- availability of necessary risk management assessments, backup planning, and/or transition planning
- service planning is developed, implemented, and revised at least annually or more frequently, as needed
- availability of and participant satisfaction with waiver services
- availability of and planning for natural/informal (unpaid) supports

## a. SERVICE PLANS

a.i. sub-assurance (4) Services are delivered in accordance with the service plan, including in the type, scope, amount, and frequency specified in the service plan.

## Performance Measure

Performance Standard =100%; Measure = total number of enrolled participants VS actual number of participants that verify they have received the appropriate services in the type, scope, amount and frequency as specified in their individual service plan.

## Data Source

Plan of Care includes:

- Service type
- Service scope
- Service amount
- Service frequency

Per Quality Assurance Survey [Quality Improvement Strategy Tool – completed “on-site” and “in-person”] Document:

I.d.i In the reviewer’s opinion, can the family follow the evacuation plan?

I.d.ii Are the child’s primary safety, health, and medical needs consistently identified and met?

I.d.iv Is the Case Manager aware of this (primary safety, health, and medical needs NOT consistently met) and have they taken appropriate steps?

VII.b Are you using natural supports in the community?

VIII.g Is there evidence that the plan of care addresses all participant needs (including health and safety risk factors)?

## a.ii. Description

The Kansas Quality Improvement Strategy includes the utilization of “on-site” and in-person interviews. Interviews are conducted by Regional State Staff persons, and in the homes of the individuals receiving services, with the consumer of the services present. The interview / QA tool completion is completed annually for 100% of the TA Waiver population. 25% of the persons served are reviewed each quarter. The Quality Survey Process includes assurance of:

- current service planning based on need, choice, and lifestyle preferences of the participant and the participant’s family
- participant’s family assists in the development of all service planning
- access to needed health care providers
- service planning to identify primary safety, health, and medical needs
- availability of necessary risk management assessments, backup planning, and/or transition planning
- service planning is developed, implemented, and revised at least annually or more frequently, as needed
- availability of and participant satisfaction with waiver services
- availability of and planning for natural/informal (unpaid) supports

## a. SERVICE PLANS

## a.i. sub-assurance (5) Participants are afforded choice:

## 1) Between waiver services and institutional care

## Performance Measure

Performance Standard =100%; Measure = total number of enrolled participants VS actual number of participants who are afforded choice between HCBS Waiver Services and Institutional care.

## Data Source

Per Quality Assurance Survey [Quality Improvement Strategy Tool – completed “on-site” and “in-person”, include are file review of pertinent documents including choice form etc.] Document:

III.c Does the family assist in the development of the Plan of Care?

VIII.f Is there evidence that a Choice Form has been signed?

## 2) Between / among waivers services and providers

## Performance Measure

Performance Standard =100%; Measure = total number of enrolled participants VS actual number of participants who are afforded choice between and among HCBS Waiver Services and providers.

## Data Source

Per Quality Assurance Survey [Quality Improvement Strategy Tool – completed “on-site” and “in-person”] Document:

III.b Do people take into account your wishes and preference (choices) when working with you?

VI.a Did you choose your Case Manager?

VI.b When a Case Manager is not doing his/her job or is disrespectful, do you feel you have the choice to change?

VI.d Has your Case Manager been helpful when you wanted to change the services you receive?

V.f Were you given choice of Case Managers in your area?

a.ii. Description

The Kansas Quality Improvement Strategy includes the utilization of “on-site” and in-person interviews. Interviews are conducted by Regional State Staff persons, and in the homes of the individuals receiving services, with the consumer of the services present. The interview / QA tool completion is completed annually for 100% of the TA Waiver population. 25% of the persons served are reviewed each quarter. The Quality Survey Process includes assurance of:

- current service planning based on need, choice, and lifestyle preferences of the participant and the participant’s family
- participant’s family assists in the development of all service planning
- service planning is developed, implemented, and revised at least annually or more frequently, as needed
- availability of and participant satisfaction with waiver services
- knowledge and choice of provider options
- availability of and planning for natural/informal (unpaid) supports
- eligibility
- changes in eligibility and preferences

These choices are documented on:

- HCBS – Technology Assisted Waiver Referral and Service Choice form and;
- Consumer Rights and Responsibilities form with the consumer / guardian signature and placed for review in the case file / individual file and reviewed during the Quality Survey Process.

a. QUALIFIED PROVIDERS

a.i. sub-assurance (1) The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other state standards prior to their furnishing waiver services.

Performance Measure

Performance Standard =100%; Measure = total number of enrolled Registered Nurse (RN) providers VS actual number of enrolled providers with current license / certification and have met training requirements.

Performance Standard =100%; Measure = total number of enrolled Licensed Practical Nurse (LPN) providers VS actual number of enrolled providers with current license / certification and have met training requirements.

Performance Standard =100%; Measure = total number of enrolled Case Management providers VS actual number of enrolled providers with current license / certification and have met training requirements.

Data Source

Per Quality Assurance Survey [Quality Improvement Strategy Tool – completed “on-site” and “in-person”] Document:

VIII.k Is there evidence that a background check has been completed for each qualified provider?

VIII.l Is there evidence of training for the position for which the staff person was hired?

Case Management Provider Qualifications:

- Advanced Registered Nurse (ARNP)

OR

- Registered Nurse (RN)

PLUS

- Bachelors Degree
- 2 years clinical experience in the nursing field
- Current license to practice in the capacity of a nurse in the State of Kansas
- Enrolled as a Medicaid provider or must be employed under an enrolled Medicaid provider authorized to provide services under the HCBS-TA Waiver
- Must successfully pass KBI, APS, CPS, KSBN, and Motor Vehicle screen

#### a. QUALIFIED PROVIDERS

a.i. sub-assurance (2) The state monitors non-licensed / non- certified providers to assure adherence to waiver requirements.

Performance Measure

Performance Standard =100%; Measure = total number of enrolled Long Term Care Service Attendant (Agency Directed) providers VS actual number of enrolled providers have met training requirements.

Performance Standard =100%; Measure = total number of enrolled self – direct providers VS actual number of enrolled providers have met training requirements.

Data Source

Per Quality Assurance Survey [Quality Improvement Strategy Tool – completed “on-site” and ”in-person”] Document:

VIII.k Is there evidence that a background check has been completed for each qualified provider?

VIII.l Is there evidence of training for the position for which the staff person was hired?

#### a. QUALIFIED PROVIDERS

a.i. sub-assurance (3) The state implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and approved waiver.

Performance Measure

Performance Standard =100%; Measure = total number of enrolled TA Waiver providers VS actual number of enrolled providers that have met established State training requirements in accordance with approved waiver.

Data Source

The Kansas Quality Improvement Strategy includes the utilization of “on-site” and in-person interviews. Interviews are conducted by Regional State Staff persons, and in the homes of the individuals receiving services, with the consumer of the services present. The interview / QA tool completion is completed annually for 100% of the TA Waiver population. 25% of the persons served are reviewed each quarter. The Quality Survey Process includes assurance of:

IV.c Do you know how and who to contact if you have a complaint, grievance, or concern regarding your child’s services?

VIII.i Is there evidence that Abuse, Neglect, and Exploitation training (reporting and prevention) has been provided to

the person and family?

VIII.j Is there evidence that Abuse, Neglect, and Exploitation training (reporting and prevention) has been provided to the attendants providing direct care services?

VIII.k Is there evidence that all staff have completed training requirements as needed to meet the needs of this individual?

VIII.l Does each staff person feel confident that they have the skills / knowledge / support to meet the needs of this individual?

#### HEALTH AND WELFARE

a.i. sub-assurance (1) The state, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.

##### Performance Measure

Performance Standard =100%; Measure = total number of enrolled TA Waiver participants / families VS number families that identify they know how to prevent, protect from, and report abuse, neglect and exploitation.

Performance Standard =100%; Measure = total number of enrolled TA Waiver providers VS number of providers with verification that adequate training has been completed to prevent, protect from, and report abuse, neglect and exploitation.

##### Data Source

Child Protective Services Data Base

Per Quality Assurance Survey [Quality Improvement Strategy Tool – completed “on-site” and “in-person”] Document:

II.a Does the family know how to protect the child from abuse / neglect?

VIII.h Is there evidence that a background check has been completed for each qualified provider?

VIII.i Is there evidence that Abuse, Neglect, and Exploitation training (reporting and prevention) has been provided to the person and family?

VIII.j Is there evidence that Abuse, Neglect, and Exploitation training (reporting and prevention) has been provided to the attendants providing direct care services.

##### Data Aggregation and Analysis

Performance Improvement TA Waiver Report provided to Kansas Health Policy Authority via the KHPA Long Term Care Committee, for review by the State Medicaid Agency (SSMA)

##### a.ii. Description

SRS/DBHS/CSS is responsible for oversight of critical events/Incidents, unauthorized use of restraints/restrictive procedures, and oversight and follow-up of appropriate medication management in accordance with Kansas regulatory and statutory requirements. Oversight of regulatory standards and statute is conducted by SRS/DBHS/CSS Regional Field Staff.

SRS Child Protective Services (CPS) is responsible for overseeing and investigating the reporting of all critical incidents and events. CPS maintains a data base of all critical incidents and events and makes available the contents of the data base to SRS/DBHS/CSS through quarterly reporting.

SRS/DBHS/CSS and SRS Child Protective Services (CPS) meet on a quarterly basis to trend data, develop evidence-based decisions, and identify opportunities for Provider improvement and/or training.

#### a. ADMINISTRATIVE AUTHORITY

a.i. (1) The Medicaid agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other State and local/regional non-State agencies (if appropriate) and contracted entities.

#### Performance Measure

Performance Standard =100%; Measure = Interagency Agreement is maintained accurately by Single State Medicaid Agency (Kansas Health Policy Authority) VS State Operating Agency (Kansas SRS/DBHS/CSS) utilizes Interagency Agreement when writing, policy / waivers / amendments and other activities .

Performance Standard =100%; Measure = Regular interagency meetings / coordination at all levels by Single State Medicaid Agency (Kansas Health Policy Authority) VS State Operating Agency (Kansas SRS/DBHS/CSS) attends and participates as outlined in Interagency Agreement / as necessary for program operation.

Performance Standard =100%; Measure = Waiver amendments / policies / waiver submissions are reviewed by Single State Medicaid Agency (Kansas Health Policy Authority) VS State Operating Agency (Kansas SRS/DBHS/CSS) provides data, input and other information as requested for effective program management.

#### Data Source

Aggregated Statewide Annual and Provider specific Data Reports

Responsible Party for Data Collection / Generation Operating Agency – Kansas SRS/DBHS/CSS

Frequency of Data Collection / Generation ANNUAL

Sampling Approach 100%

#### Data Aggregation and Analysis

Performance Improvement Data Aggregation (Central Office Performance Improvement Program Manager)

Performance Improvement Analysis Process including:

Performance Improvement Executive Review Committee (Central Office Assistant Director & Performance Improvement Program Manager w/ Waiver Program Managers

Performance Improvement TA Waiver Report provided to Kansas Health Policy Authority via the KHPA Long Term Care Committee, for review by the State Medicaid Agency (SSMA)

Responsible Party for Data Aggregation and Analysis Operating Agency – Kansas SRS/DBHS/CSS

Frequency of Data Aggregation and Analysis ANNUAL

#### b.i. Methods for Remediation / fixing Individual Problems

The contracted entities (Providers) and SRS (Social and Rehabilitation Services) have an interagency agreement which includes, but is not limited to:

- Disseminate information concerning the waiver to potential enrollees
- Assist individuals in waiver enrollment
- Conduct level of care evaluation activities
- Review participant service plans to ensure that waiver requirements are met
- Recruit providers
- Conducting utilization management functions

- Determination of waiver payment amounts or rates

The state's fiscal agent conducts surveillance and utilization reviews of contracted entities based on referral. Meetings are held on a quarterly basis between SRS (Waiver Operating Agency), the Medicaid agency and the fiscal agent.

The fiscal agent is available to provide training and technical assistance to contracted entities, as needed.

#### a.ii. Description

Regular interagency meetings are held at all levels. There are interagency meetings at the secretary and deputy secretary levels. A monthly long-term care meeting brings together expertise from all the operating agencies to review and discuss what is happening in the provision of long-term care services in the state.

Expectations on the communication and planning for future programs or program expansions utilizing Medicaid funding have been relayed to other operating agencies. Interagency agreements have been signed or are in the process of being developed and/or reviewed for potential signature. Those agreements will be reviewed annually and updated as needed. KHPA staff consults with other operating agencies in the development of policy, design of implementation strategies, forming of change orders processing through the MMIS and in many other areas which support program integrity.

The Interagency Coordination unit (ICU) consists of three persons: the program integrity manager, an interagency liaison and the manager of state plans and regulation. This team is responsible for consulting and reviewing and in some cases developing state plan amendments, waiver submissions, including the 372 financial reports and interagency agreements. The ICU staff participates in both formal and informal oversight activities which can include review of documents, participating in planning and development meetings and oversight meetings. The ICU can make recommendations to executive staff related to the operation of programs using Medicaid funding.

#### b.i. Remediation Data Aggregation

All remediation activities are handled through the concepts as outlined in the interagency agreement.

Responsible Party Operating Agency – Kansas SRS/DBHS/CSS

Frequency of Data Aggregation and Analysis ANNUAL

#### a. FINANCIAL ACCOUNTABILITY

a.i. (1) State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

#### Performance Measure

Performance Standard =100%; Measure = Claims received and coded in accordance with the reimbursement methodology specified in the approved waiver VS claims paid for in accordance with the reimbursement methodology specified in the approved waiver.

#### Data Source

POC Data Base

Medicaid Management Information System (MMIS)

Responsible Party for Data Collection / Generation Operating Agency – Kansas SRS/DBHS/CSS

Frequency of Data Collection / Generation ANNUAL

Sampling Approach 100%

Data Aggregation and Analysis

Performance Improvement Data Aggregation (Central Office Performance Improvement Program Manager)

Performance Improvement Analysis Process including:

Community Choice Reflection Team (100% consumer members) review of statewide data versus local provider trends)

Performance Improvement Review Committee (Central Office PI Program Manager w/ Regional SRS field staff)

Performance Improvement Executive Review Committee (Central Office Assistant Director & Performance Improvement Program Manager w/ Waiver Program Managers

Performance Improvement TA Waiver Report provided to Kansas Health Policy Authority via the KHPA Long Term Care Committee, for review by the State Medicaid Agency (SSMA)

Responsible Party for Data Aggregation and Analysis Operating Agency – Kansas SRS/DBHS/CSS

Frequency of Data Aggregation and Analysis ANNUAL

b.i. Methods for Remediation / fixing Individual Problems

All claims are processed through an approved Medicaid Management Information System (MMIS). All payments made for waiver services are subject to service utilization review audits completed at random by Electronic Data Systems (EDS), the contractor for MMIS. The Medicaid agency makes payments directly to providers of waiver services. The Prior Authorization Sub-system and automated Plans of Care ensure more accurate authorization and payment of HCBS services a more accurate audit trail for reviews. Payments are made only when the individual is approved to receive Medicaid waiver payment for the date of service and for the service for which the bill is submitted.

a.ii. Description

A Plan of Care (POC) is developed for all persons served through the waiver. These POCs are completed electronically and approved by the State of Kansas. Billing for waiver services are submitted into MMIS which electronically searches the POC data base to ensure each individual is approved to receive Medicaid waiver payment for the date of service and for the service for which the bill is submitted. The provider enrollment process includes agreement by the provider to post pay reviews of claims (K.A.R. 30-5-59; K.A.R. 30-5-70)

b.i. Remediation Data Aggregation

The state's fiscal agent conducts surveillance and utilization reviews of contracted entities based on referral. Meetings are held on a quarterly basis between SRS (Waiver Operating Agency), the Medicaid agency and the fiscal agent.

The fiscal agent is available to provide training and technical assistance to contracted entities, as needed.

Responsible Party Operating Agency – Kansas  
SRS/DBHS/CSS

Frequency of Data Aggregation and Analysis ANNUAL

H.1. Systems Improvement

H.1.a.i. Kansas Quality Improvement Strategy – Systems Improvement

The KQIS provides oversight, monitoring and continuous improvement strategies in accordance with the Division of Disability & Behavioral Health Services / Community Supports and Services long term plan for the development, implementation and monitoring of the entire spectrum of quality management including the discovery activities. The Quality Improvement system is data-based and outcome-focused. The system provides for data-based decision making to improve the individual lives of each participant while pro-actively building statewide capacity. The KQIS is a two-prong approach utilizing identification minimum standard compliance and assurance of corrective action to address systematic weaknesses while simultaneously utilizing the data to identify best practices to promote participant independence, productivity, community inclusion and opportunities for systems improvement to promote participant quality of life.

DBHS / CSS manage the KQIS through a network of Regional SRS offices. The Regional offices are provided the specific desired outcomes that are to be achieved. These outcomes are developed in accordance with the Waiver Assurances, provider qualification licensing standards / monitoring requirement outcomes and corrective action /

remediation outcomes. The regional offices are responsible to achieve the outcomes through an effective utilization of human and fiscal resources. The Central Office (DBHS/CSS Leadership / program management) is responsible to develop / implement / monitor and assess the continued effectiveness of all programs operated by the State Medicaid Operating Agency.

The KQIS is developed on five year cycles. The cycle includes utilization of a continuous discovery / aggregation / trending / communication / remediation and follow-up activities as described in the KQIS. During the 4th year of the KQIS the strategy is opened for intentional review. The review includes a complete evaluation at 3 levels: First: Public Review of the plan / requirements and methodologies and all processes that are achieved. Second: An internal state review which may include external review by an impartial party. Third: Report of findings to the State Medicaid Agency with recommendations for improvement.

#### H.1.a.ii. Kansas Quality Improvement Strategy – Improvement Activities

Responsible parties / individuals: Data Collection / discovery and remediation activities – assigned to the Quality Assurance Program Manager in Central Office and performed by SRS Regional Quality Assurance staff.

Performance Improvement activities including operation of the KQIS, Waiver Application Appendix H and assurance/sub assurance performance monitoring requirements and performance outcome measures development – data trending / tracking / compilation / communication - assigned to the: Performance Improvement Program Manager in Central Office and performed by SRS

Performance Improvement Analysis Process including:

Community Choice Reflection Team (100% consumer members) review of statewide data versus local provider trends)

Performance Improvement Review Committee (Central Office PI Program Manager w/ Regional SRS field staff)

Performance Improvement Executive Review Committee (Central Office Assistant Director & Performance Improvement Program Manager w/ Waiver Program Managers

Performance Improvement TA Waiver Report provided to Kansas Health Policy Authority via the KHPA Long Term Care Committee, for review by the State Medicaid Agency (SSMA)

Responsible Party Operating Agency – Kansas SRS/DBHS/CSS

Frequency of Monitoring and Analysis ANNUAL

Timelines: Data Review Process; CCRT Planner

\*\*\*APPLICABLE TO ALL SUB-ASSURANCES ABOVE\*\*\*

Data Aggregation and Analysis

Performance Improvement Data Aggregation (Central Office Performance Improvement Program Manager)

Performance Improvement Analysis Process including:

Community Choice Reflection Team (100% consumer members) review of statewide data versus local provider trends)

Performance Improvement Review Committee (Central Office PI Program Manager w/ Regional SRS field staff)

Performance Improvement Executive Review Committee (Central Office Assistant Director & Performance Improvement Program Manager w/ Waiver Program Managers

Performance Improvement TA Waiver Report provided to Kansas Health Policy Authority via the KHPA Long Term Care Committee, for review by the State Medicaid Agency (SSMA)

Responsible Party for Data Collection / Generation Operating Agency – Kansas SRS/DBHS/CSS

Frequency of Data Collection / Generation ANNUAL

**Methods for Remediation / fixing Individual Problems**

Providers are informed of all quality and performance improvement indicators and performance standards. Based on any noted deficiencies identified through the Quality Survey Process, state staff (Regional Field Staff – Quality Assurance) request Corrective Action Plans from providers for remediation. State staff provides technical assistance, as appropriate.

Responsible Party for Data Collection / Generation Operating Agency – Kansas SRS/DBHS/CSS

Frequency of Data Collection / Generation ANNUAL

Sampling Approach 100%

**Description**

The above performance standards have been developed in partnership with consumers, advocates, provider organizations and state operating and authority agencies to monitor waiver assurances and minimum standards. The performance standards are monitored through the current Quality Survey Process which is based on a uniform, standard assessment instrument and is implemented and utilized statewide. The Quality Survey process is conducted by state staff (Regional Field Staff – Quality Assurance) through annual on-site, in person reviews of 100% of waiver participants to review for and address any identified occurrences of non-compliance with regulatory and performance standards.

State staff (Regional Field Staff – Quality Assurance) conduct Quality Survey reviews in accordance with the Quality Survey Process to review for and address any identified occurrences of non-compliance with regulatory standards and minimum performance standards; including Individualized Plan of Care review / Individual Behavior Support Planning / License, Education, and Certification Review / Background Check Review / Record reviews, on-site / Training verification records / On-site observations, interviews, monitoring / Analyzed collected data (including surveys, focus groups, interviews) / Trends, remediation actions proposed and taken / Provider performance monitoring / Staff observation and opinion / Participant and family observation and interview / Critical event and incident report monitoring / Child Protective Services Reports and findings / Death reporting / Program data review / Medication administration data report and log review.

**Remediation Data Aggregation**

Statewide / Regional / Provider data is compiled, trended, reviewed, and disseminated to providers through the Performance Improvement Analysis Process. Each provider receives annual data trending which identifies Provider specific performance levels related to statewide performance standards and statewide averages. Corrective Action Plan requests and/or technical assistance to remediate negative trending are included in annual provider reports where negative trending is evidenced.

The Performance Improvement Executive Committee generates corrective action planning and improvement planning which is submitted to the Director of SRS/DBHS/CSS of the Medicaid Operating Agency for review and approval/denial and sent to the Kansas Health Policy Authority via the KHPA Long Term Care Committee for review by the State Medicaid Agency (SSMA). The approval/denial from the Director of SRS/DBHS/CSS would be returned to the Performance Improvement Executive Committee for corrective action or planning for implementation of improvement.

Responsible Party Operating Agency – Kansas SRS/DBHS/CSS

Frequency of Data Aggregation and Analysis ANNUAL

**Appendix I: Financial Accountability****I-1: Financial Integrity and Accountability**

**Financial Integrity.** Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the

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

The Division of Legislative Post Audit contracts with an independent accounting firm to complete Kansas' state wide single audit each year. The accounting firm must comply with all requirements contained in the single audit act. The Medicaid program, including all home and community based services waivers, is a required component of every single state audit.

Independent audits of the waiver will look at cost-effectiveness, the quality of services, service access, and the substantiation of claims for HCBS payments. Each HCBS provider is to permit the Social and Rehabilitation Services, its designee, or any other governmental agency acting in its official capacity to examine any records and documents that are necessary to ascertain information pertinent to the determination of the proper amount of a payment due from the Medicaid program. The Surveillance and Utilization Review Unit of the fiscal agent completes the audits of both participants and providers (K.A.R. 30-5-59, K.A.R. 30-5-303).

All claims are processed through an approved Medicaid Management Information System (MMIS). All payments made for waiver services are subject to service utilization review audits completed at random by the contractor for MMIS, Electronic Data Systems (EDS). The Medicaid agency makes payments directly to providers of waiver services. The Prior Authorization Sub-system and automated Plans of Care ensure more accurate authorization and payment of HCBS services and a more accurate audit trail for reviews.

In place are:

- 1) Provider agreements signed by prospective providers during the enrollment process;
- 2) Contract monitoring activities;
- 3) An HCBS data base for tracking HCBS data collected from the QA initiative completed by SRS/DBHS/CSS Regional Field Staff; and
- 4) The Long Term Care Services Threshold Determinations required by the waiver.

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (1 of 3)

- a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Reimbursement for services is based upon a Medicaid fee schedule established by the State of Kansas. Commercial third party payers and market rates will be considered when establishing the fee schedules. These reimbursement methodologies will produce rates sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that these services are available to the general population, as required by 42 CFR 447.204. These rates comply with the requirements of Section 1902(a)(3) of the Social Security Act 42 CFR 447.200, regarding payments and consistent with economy, efficiency and quality of care. Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained. The Medicaid fee schedule will be equal to or less than the maximum allowable under the same Medicare rate, if applicable. If a service has no Kansas specific Medicare rate, Kansas will establish pricing based on similar services. Room and board costs are not included in the Medicaid fee schedule.

In reference to long-term community attendant services, rates are set differently for self-directed and agency-directed services as different types of providers submit claims for those services. Agency-directed attendant services are provided by an employee of a home health agency regulated by the Kansas Department of Health and Environment (KDHE). Self-directed agencies act as payroll agents for participants who choose to self-direct waiver services.

Through interagency agreement, SRS is responsible for the waivers which resided there prior to the removal of the Medicaid agency from SRS. This would include the determination of rates. Should there be a change in methodology KHPA would need to review the proposed change. Any rate change is expected to be presented through a state plan amendment, waiver amendment or policy which would be reviewed by administrative staff of KHPA before implementation.

When a change in method for how rates are determined occurs, public comments are solicited for consideration along with reimbursements based on Commercial third party payers and the current market rates for similar services. SRS is responsible for ensuring the change in method is reviewed by KHPA (SSMA) prior to implementation. Provider payment rates for waiver services are made available to participants, providers and general public upon request.

TA waiver case management entities are a source of information and a resource for questions from the general public and those applying for HCBS-TA waiver with questions regarding waiver services.

- b. **Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Claims for services are submitted to the state Medicaid fiscal agency directly from waiver provider contractors/agencies or from payroll agencies for those individuals self-directing their services. All claims are processed through paper claim format or through the Medicaid Management Information System (MMIS). Payments are made only when the consumer was eligible for Medicaid waiver payment on the date and time of service, and when the service was included in the approved plan of care.

**Appendix I: Financial Accountability**

**I-2: Rates, Billing and Claims (2 of 3)**

- c. **Certifying Public Expenditures (select one):**

- No. Public agencies do not certify expenditures for waiver services.**
- Yes. Public agencies directly expend funds for part or all of the cost of waiver services and certify their public expenditures (CPE) in lieu of billing that amount to Medicaid.**

Select at least one:

- Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the public agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-a.)

- Certified Public Expenditures (CPE) of Non-State Public Agencies.**

Specify: (a) the non-State public agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

**Appendix I: Financial Accountability**

**I-2: Rates, Billing and Claims (3 of 3)**

- d. **Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

A plan of care (POC) is developed for all persons served through the waiver. These POCs are completed electronically and approved by the State of Kansas. When a waiver bill is submitted the MMIS electronically searches the POC data base to ensure that the individual was approved to receive Medicaid waiver payment for the date of service for the service for which the bill is submitted. Reviews to validate that services were in fact provided as billed is part of the financial integrity reviews described above. Providers agree, during the provider enrollment process, to post pay reviews of their claims (K.A.R. 30-5-59; K.A.R. 30-5-70).

- e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §74.53.

## Appendix I: Financial Accountability

### I-3: Payment (1 of 7)

- a. **Method of payments -- MMIS (select one):**

- Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

## Appendix I: Financial Accountability

### I-3: Payment (2 of 7)

b. **Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

### Appendix I: Financial Accountability

#### I-3: Payment (3 of 7)

c. **Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- No. The State does not make supplemental or enhanced payments for waiver services.**
- Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe:(a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made and (b) the types of providers to which such payments are made. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

### Appendix I: Financial Accountability

#### I-3: Payment (4 of 7)

d. **Payments to Public Providers.** *Specify whether public providers receive payment for the provision of waiver services.*

- No. Public providers do not receive payment for waiver services. Do not complete Item I-3-e.**
- Yes. Public providers receive payment for waiver services. Complete Item I-3-e.**

Specify the types of public providers that receive payment for waiver services and the services that the public providers furnish: *Complete item I-3-e.*

	 
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## Appendix I: Financial Accountability

### I-3: Payment (5 of 7)

#### e. Amount of Payment to Public Providers.

Specify whether any public provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

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

- The amount paid to public providers is the same as the amount paid to private providers of the same service.
- The amount paid to public providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
- The amount paid to public providers differs from the amount paid to private providers of the same service. When a public provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

	 
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## Appendix I: Financial Accountability

### I-3: Payment (6 of 7)

f. **Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
- Providers do not receive and retain 100 percent of the amount claimed to CMS for waiver services.

Provide a full description of the billing, claims, or payment processes that result in less than 100% reimbursement of providers. Include: (a) the methodology for reduced or returned payments; (b) a complete listing of types of providers, the amount or percentage of payments that are reduced or returned; and, (c) the disposition and use of the funds retained or returned to the State (i.e., general fund, medical services account, etc.):

	 
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- Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

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## Appendix I: Financial Accountability

### I-3: Payment (7 of 7)

#### g. Additional Payment Arrangements

##### i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.
- Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

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##### ii. Organized Health Care Delivery System. *Select one:*

- No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.
- Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

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##### iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.
- The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and,

(d) how payments are made to the health plans.

	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (1 of 3)

- a. **State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

- Appropriation of State Tax Revenues to the State Medicaid agency  
 Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by public agencies as CPEs, as indicated in Item I-2-c:

The non-federal share of the waiver expenditures is from direct state appropriations to the Department of Social and Rehabilitation Services (SRS). SRS, through agreement with the single state Medicaid agency, the Kansas Health Care Authority. The non-federal share of the waiver expenditures are directly expended by SRS.

- Other State Level Source(s) of Funds.

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by public agencies as CPEs, as indicated in Item I-2-c:

	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (2 of 3)

- b. **Local or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One:*

**Not Applicable.** There are no non-State level sources of funds for the non-federal share.

**Applicable**

*Check each that applies:*

- Appropriation of Local Revenues.**

Specify: (a) the local entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by public agencies as CPEs, as

specified in Item I-2- c:

[Empty text box]

**Other non-State Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:

[Empty text box]

**Appendix I: Financial Accountability**

**I-4: Non-Federal Matching Funds (3 of 3)**

c. **Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) provider taxes or fees; (b) provider donations; and/or, (c) federal funds (other than FFP). *Select one:*

**None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

**The following source(s) are used**

*Check each that applies:*

**Provider taxes or fees**

**Provider donations**

**Federal funds (other than FFP)**

For each source of funds indicated above, describe the source of the funds in detail:

[Empty text box]

**Appendix I: Financial Accountability**

**I-5: Exclusion of Medicaid Payment for Room and Board**

a. **Services Furnished in Residential Settings.** *Select one:*

**No services under this waiver are furnished in residential settings other than the private residence of the individual.**

**As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

**Do not complete this item.**

[Empty text box]

**Appendix I: Financial Accountability****I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver**

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.
- Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

**Appendix I: Financial Accountability****I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)**

- a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- No. The State does not impose a co-payment or similar charge upon participants for waiver services.
- Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.
- i. **Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

*Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- Nominal deductible
- Coinsurance
- Co-Payment
- Other charge

*Specify:*

**Appendix I: Financial Accountability****I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)**

- a. Co-Payment Requirements.
- ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

**Appendix I: Financial Accountability****I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)**

- a. Co-Payment Requirements.
- iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

**Appendix I: Financial Accountability****I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)**

- a. Co-Payment Requirements.
- iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

**Appendix I: Financial Accountability****I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)**

- b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

- No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
- Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

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**Appendix J: Cost Neutrality Demonstration**

**J-1: Composite Overview and Demonstration of Cost-Neutrality Formula**

**Composite Overview.** Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: Hospital

Col. 1 Year	Col. 2 Factor D	Col. 3 Factor D'	Col. 4 Total: D+D'	Col. 5 Factor G	Col. 6 Factor G'	Col. 7 Total: G+G'	Col. 8 Difference (Col 7 less Column4)
1	56035.30	66964.00	122999.30	159952.00	3521.00	163473.00	40473.70
2	56831.29	69576.00	126407.29	166190.00	3658.00	169848.00	43440.71
3	59072.42	72289.00	131361.42	172671.00	3801.00	176472.00	45110.58
4	61405.37	75108.00	136513.37	179405.00	3949.00	183354.00	46840.63
5	63507.63	78037.00	141544.63	186402.00	1403.00	187805.00	46260.37

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (1 of 9)**

- a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Hospital	
Year 1	407	407	
Year 2	412	412	
Year 3	417	417	
Year 4 (renewal only)	422	422	
Year 5 (renewal only)	428	428	

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (2 of 9)**

- b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay is based upon MAR-4021 for Waiver 40165 TA Waiver Services Report 03/01/06 to 02/29/07, total days of waived coverage divided by unduplicated consumers.

**Appendix J: Cost Neutrality Demonstration**

c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Factor D is based upon FY 2007 unduplicated participant counts in the Kansas Medical Assistance Report and DSS data for paid claims FY 2007 by procedure codes utilized in the TA Waiver, the Attendant Care for Independent Living Program and for qualifying DD Waiver children for anticipated consumer usage. Projections were calculated utilizing a small estimated population increase percentage of < 2% and a 3.9% inflation rate for medical and nursing costs (CPI, BLS for Medical Care, seasonally adjusted February 2008).

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' is based upon per capital acute care services for consumers in Waiver 40165 TA Waiver Services Report (03/06/07 to 02/29/07) and projected through FY 2013 with an inflation rate of 3.9% (CPI, BLS Medical Care, Feb 2008).

MMIS/DSS data can be utilized to ascertain those participants who are also medicare qualified and remove them from the prescription drug calculations for D'.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G is based upon average cost per person per day for the state's two MRDD hospitals for FY 2007 and is also projected with a 3.9% inflation rate through FY 2013.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' utilizes the per capita acute care services for institutionalized consumers reported in The DD Waiver 0224 MRDD Waiver Services Report (7/01/06 to 06/30/07), projected through FY 2013 with the Feb 2008 CPI BLS Medical Care 3.9% inflation rate.

MMIS/DSS data can be utilized to ascertain those participants who are also medicare qualified and remove them from the prescription drug calculations for G'.

## Appendix J: Cost Neutrality Demonstration

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### J-2: Derivation of Estimates (4 of 9)

**Component management for waiver services.** If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

## Appendix J: Cost Neutrality Demonstration

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### J-2: Derivation of Estimates (5 of 9)

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 1**

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Long-term Community Care Attendant Service Total:</b>						4063786.25
Personal Service Attendant (Self-direct)	1=15 minutes	85	11680.00	3.75	3723000.00	
Medical Service Technician (Agency-direct)	1=15 minutes	35	2291.00	4.25	340786.25	
<b>Independent Case Management Total:</b>						1359375.00
Independent Case Management	1= 15 minutes	375	290.00	12.50	1359375.00	
<b>Home Modification Total:</b>						703125.00
Home Modification	1= \$7500.00	375	0.25	7500.00	703125.00	
<b>Medical Respite Care Total:</b>						5082.00
Medical Respite Care	1= 15 minutes	22	33.00	7.00	5082.00	
<b>Specialized Medical Care Total:</b>						16675000.00
Specialized Medical Care - RN	1= 15 minutes	75	6000.00	7.50	3375000.00	
Specialized Medical Care - LPN	1= 15 minutes	190	10000.00	7.00	13300000.00	
<b>GRAND TOTAL:</b>						22806368.25
Total Estimated Unduplicated Participants:						407
Factor D (Divide total by number of participants):						56035.30
Average Length of Stay on the Waiver:						295

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (6 of 9)**

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 2**

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Long-term Community Care Attendant Service Total:</b>						4282015.92
Personal Service Attendant (Self-direct)	1= 15 minutes	86	11680.00	3.90	3917472.00	

Medical Service Technician (Agency-direct)	1= 15 minutes	36	2291.00	4.42	364543.92	
<b>Independent Case Management Total:</b>						1431498.00
Independent Case Management	1= 15 minutes	380	290.00	12.99	1431498.00	
<b>Home Modification Total:</b>						185060.00
Home Modification	1= \$ 7500.00	380	0.25	1948.00	185060.00	
<b>Medical Respite Care Total:</b>						5278.02
Medical Respite Care	1= 15 minutes	22	33.00	7.27	5278.02	
<b>Specialized Medical Care Total:</b>						17510640.00
Specialized Medical Care - RN	1= 15 minutes	76	6000.00	7.79	3552240.00	
Specialized Medical Care - LPN	1= 15 minutes	192	10000.00	7.27	13958400.00	
<b>GRAND TOTAL:</b>					23414491.94	
Total Estimated Unduplicated Participants:					412	
Factor D (Divide total by number of participants):					56831.29	
Average Length of Stay on the Waiver:						295

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (7 of 9)**

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 3**

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Long-term Community Care Attendant Service Total:</b>						4446708.84
Personal Service Attendant (Self-direct)	1= 15 minutes	86	11680.00	4.05	4068144.00	
Medical Service Technician (Agency-direct)	1= 15 minutes	36	2291.00	4.59	378564.84	
<b>Independent Case Management Total:</b>						1502246.40
Independent Case Management	1= 15 minutes	384	290.00	13.49	1502246.40	
<b>Home Modification Total:</b>						194304.00
Home Modification	1= \$7500.00	384	0.25	2024.00	194304.00	
<b>Medical Respite Care Total:</b>						5738.04
Medical Respite Care	1= 15 minutes	23	33.00	7.56	5738.04	
Specialized Medical Care						

<b>Total:</b>						18484200.00
Specialized Medical Care - RN	1= 15 minutes	77	6000.00	8.10	3742200.00	
Specialized Medical Care - LPN	1= 15 minutes	195	10000.00	7.56	14742000.00	
<b>GRAND TOTAL:</b>						24633197.28
Total Estimated Unduplicated Participants:						417
Factor D (Divide total by number of participants):						59072.42
Average Length of Stay on the Waiver:						295

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (8 of 9)**

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 4 (renewal only)**

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (9 of 9)**

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 5 (renewal only)**

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Long-term Community Care Attendant Service Total:</b>						5024681.10
Personal Service Attendant (Self-direct)	1= 15 minutes	90	11680.00	4.37	4593744.00	
Medical Service Technician (Agency-direct)	1= 15 minutes	38	2291.00	4.95	430937.10	
<b>Independent Case Management Total:</b>						1664768.20
Independent Case Management	1= 15 minutes	394	290.00	14.57	1664768.20	
<b>Home Modification Total:</b>						215222.50
Home Modification	1= \$7500.00	394	0.25	2185.00	215222.50	
<b>Medical Respite Care Total:</b>						6193.44
Medical Respite Care	1= 15 minutes	23	33.00	8.16	6193.44	
<b>Specialized Medical Care Total:</b>						20270400.00
Specialized Medical Care - RN	1= 15 minutes	80	6000.00	8.74	4195200.00	
Specialized Medical Care - LPN	1= 15 minutes	197	10000.00	8.16	16075200.00	
<b>GRAND TOTAL:</b>						27181265.24
Total Estimated Unduplicated Participants:						428
Factor D (Divide total by number of participants):						63507.63
Average Length of Stay on the Waiver:						295