

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

## PURPOSE OF THE HCBS WAIVER PROGRAM

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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

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

- 1) Kansas has developed a transition plan for the HCBS/Autism settings that will assess and ensure Kansas provider settings meet the requirements of the HCBS Final Setting Rule.
- 2) Kansas has removed the following services from the Autism Waiver and has placed them in the State Plan. Autism Specialist has been removed throughout and replaced as appropriate.
  - o Consultative Clinical and Therapeutic Services (Autism Specialist)
  - o Intensive Individual Supports
  - o Interpersonal Communication Therapy
- 3) Kansas is proposing general language:
  - References to "Individual," "consumer," or "beneficiary" have been changed to "participant" consistent with CMS language
  - "Kaw Valley Center (KVC)" has been changed to "contracted assessor" consistent across all programs.
  - "Vineland II Survey Interview Adaptive Behavior Scales" has been changed to "Functional Eligibility Instrument (FEI)."
- 4) Kansas is proposing general grammatical changes or corrections throughout the waiver, as needed.
- 5) Kansas is proposing reserved capacity for military personnel dependents entering into HCBS/Autism services.
- 6) Kansas is proposing reserved capacity for participants who have gone into a facility or hospital for a temporary stay. This allows participants who have moved into a facility temporarily to have their position on the program reserved while until their temporary stay ends.
- 7) Kansas has proposed language regarding potential restraints and seclusions within the HCBS/Autism program.
- 8) Kansas has proposed a requirement of back ground checks for all services and assessors and proposed language regarding prohibited offenses that states "Any provider found identified to have been substantiated for prohibited offenses as listed in KSA 39-970 & 65-5117 is not eligible for reimbursement of services under Medicaid funding."
- 9) Kansas has proposed to separate Performance Measures in Appendix G of the Autism Waiver to be consistent with the sub-assurances with other waivers. The performance measures will not be changed. All sub-assurances will be moved to

the appropriate Performance Measure heading within this sub-section of the appendix.

10) Kansas is proposed updated language in Appendix C for all service providers under Verification of Provider Qualifications with:

“Kansas provides monitoring and oversight of MCO's verification of HCBS-Autism provider qualifications. This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.”

11) Kansas updated all of the taxonomy information in Appendix C for all waiver services.

12) Kansas is proposing additional language to offer an alternative option for service delivery through telemedicine for Family Adjustment Counseling and/or Parent Support and Training (peer to peer) services.

This provision of service delivery will be subject to program manager approval and documentation requirements that must be submitted by the KanCare MCOs that all options to locate providers have been exhausted.

This documentation will include, at a minimum, three (3) written statements from service providers within at least a 50 mile radius of the family's residence on the provider's company letterhead indicating that the family lives in an area that is so remote they will not deliver these services face-to-face.

13) Kansas has updated the projected number served for the next five (5) years in Appendix B.

14) Kansas is proposing changing Appendix B-4(b), to be consistent with previous CMS guidance on other waiver renewals.

15) Kansas is proposing to allow children to transition solely to the HCBS-IDD waiver.

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

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

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**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*):

**Autism Waiver**

**C. Type of Request: renewal**

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

3 years  5 years

**Waiver Number:** KS.0476.R02.00

**Draft ID:** KS.004.02.00

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

Regular Waiver

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

01/01/16

### 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:

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

**Nursing Facility**  
Select applicable level of care

**Nursing Facility as defined in 42 CFR §§440.40 and 42 CFR §§440.155**  
If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

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

**Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**  
If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:

## 1. Request Information (3 of 3)

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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)(1)(a) of the Act and described in Appendix I**

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

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

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

**§1915(b)(1) (mandated enrollment to managed care)**

**§1915(b)(2) (central broker)**

**§1915(b)(3) (employ cost savings to furnish additional services)**

**§1915(b)(4) (selective contracting/limit number of providers)**

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

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

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

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

**A program authorized under §1115 of the Act.**

Specify the program:

KanCare 1115 Demonstration Project

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

Check if applicable:

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

## 2. Brief Waiver Description

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**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 purpose of the Kansas Autism Waiver is to provide eligible Kansans the option to receive early intensive interventions in their home and community in a cost-efficient manner. The goal of the Autism Waiver is to divert children from entering an inpatient psychiatric facility for individuals age 21 and under as provided in 42CFR440.160 by providing early intensive intervention treatment. Autism Waiver services are available to children who have received a diagnosis of an Autism Spectrum Disorder (ASD), including Autism, Asperger Syndrome, and Other Pervasive Developmental Disorder-Not Otherwise Specified from a licensed Medical Doctor or Ph.D. Psychologist using an approved Autism specific screening tool. Since research has shown that early intensive interventions with ASD children are effective, a child must be between the age of zero through their fifth year of age upon entering the waiver and be financially eligible for Medicaid. Children must also meet the Level of Care eligibility determination conducted initially and annually by a qualified Functional Eligibility Specialist. The level of care instrument used to determine initial and annual eligibility for the Autism waiver must be the state approved functional eligibility instrument. The Kansas Autism Waiver has a service limit of three years with a one time, one year extension possible if deemed medically necessary. The Kansas Autism Waiver provides three distinctive services to participants and their families. These services are: Respite Care, Parent Support and Training (peer to peer) Provider, and Family Adjustment Counseling.

Each waiver participant will have a plan of care (POC). The POC is developed by the Managed Care Organization (MCO) and will describe waiver services the child is to receive, their frequency, and the type of provider who is to furnish each service. All waiver services will be furnished pursuant to a written plan of care. The plan of care will be subject to the approval by the selected KanCare MCO. Federal Financial Participation (FFP) will not be claimed for waiver services which are not included in the child's written plan of care.

Programmatic oversight and control of the waiver is provided by Kansas Department for Aging and Disability Services (KDADS). KDADS has taken the necessary safeguards to protect the health and welfare of children receiving services under this waiver by setting adequate standards for all types of providers that furnish HCBS/Autism waiver services; those standards of any State licensure or certification requirements are met for services or for individuals furnishing services through the waiver.

## 3. Components of the Waiver Request

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

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

- Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
  - No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*
- F. Participant Rights.** Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

- G. Participant Safeguards.** **Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy.** **Appendix H** contains the Quality Improvement Strategy for this waiver.
- I. Financial Accountability.** **Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration.** **Appendix J** contains the State's demonstration that the waiver is cost-neutral.

#### 4. Waiver(s) Requested

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

No

Yes

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

- Geographic Limitation.** A waiver of statewide is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.

*Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

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

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

#### 5. Assurances

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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:
- 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

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

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver:  
Tribal notice was sent on 08/27/15 to inform tribal leaders of intent to renew the Autism waiver. Public/ Stakeholder Input was received February 26, 2015 and September 28, 2015.

KDADS conducted public input sessions February 4 and 5 (in person), and 10 (by conference call), 2015 (morning and afternoon sessions) and September 25 (in person and by conference call), 2015 to present HCBS-Autism program proposed changes, specific transition plans and the renewal. KDADS sought public input at regional in-

person meetings, via teleconference and other non-electronic formats. KDADS received several comments/ feedback a few comments relating to the HCBS-Autism specific proposals.

Three (3) comments relating to the proposal for the use of Telemedicine for as a service delivery option for Parent Support and Training (peer to peer) services.

A full copy of the waiver could be provided by the participant's MCO care coordinator, Autism waiver service provider, and/or the Kansas Department for Aging and Disability Services (KDADS) upon request.

The state provided information in the Kansas Register, Home and Community Based Services bulletins, the KDADS website, and news articles.

KDADS compiled and discussed all comments and feedbacks for additional consideration. Following the review, KDADS provided response to comments and feedback in the form of an FAQ or made changes to the proposal in the final submission to CMS. By majority, KDADS clarified and responded to questions and comments at the time of the presentation, onsite and in-person.

All public session opportunities related to the HCBS Final Rule and proposed renewal along with the public comments are available on the KDADS website at [www.kdads.ks.gov](http://www.kdads.ks.gov)

**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:**

Seymour-Hunter

**First Name:**

Fran

**Title:**

Interagency Liaison

**Agency:**

Kansas Department of Health and Environment

**Address:**

900 SW Jackson

**Address 2:**

Room 900 N

**City:**

Topeka

**State:**

**Kansas**

**Zip:**

66612-1220

**Phone:**

(785) 296-2212

Ext:   TTY**Fax:**

(785) 296-4813

**E-mail:**

fseymour-hunter@kdheks.gov

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

Sam

**First Name:**

Philbern

**Title:**

Program Manager

**Agency:**

Kansas Department for Aging and Disability Services

**Address:**

503 S. Kansas Ave.

**Address 2:****City:**

Topeka

**State:****Kansas****Zip:**

66603-3404

**Phone:**

(785) 296-6843

Ext:   TTY**Fax:**

(785) 296-0256

**E-mail:**

samuel.philbern@ks.gov

## 8. Authorizing Signature

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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:**

State Medicaid Director or Designee

**Submission Date:**

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

**Last Name:**

**First Name:**

**Title:**

**Agency:**

**Address:**

**Address 2:**

**City:**

**State:** **Kansas**

**Zip:**

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

**Fax:**

**E-mail:**

**Attachments**

**Attachment #1: Transition Plan**

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

- Replacing an approved waiver with this waiver.**
- Combining waivers.**
- Splitting one waiver into two waivers.**
- Eliminating a service.**
- Adding or decreasing an individual cost limit pertaining to eligibility.**
- Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- Reducing the unduplicated count of participants (Factor C).**
- Adding new, or decreasing, a limitation on the number of participants served at any point in time.**

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

Specify the transition plan for the waiver:

See narrative below.

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

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

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

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

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

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

The new Home and Community Based Services (HCBS) Settings Rule from the Centers for Medicare and Medicaid Services (CMS) applies to all programs that provide HCBS. In Kansas, this rule will apply to all settings where HCBS are provided, HCBS-Autism services are typically provided in the consumer's place of residence in the community.

This Transition Plan ensures the HCBS-Autism program is in compliance with the new settings requirements and meets the expectations of CMS, prior to submission of the HCBS-Autism Transition Plan. The final Transition Plan will incorporate changes relating to the comments and feedback from CMS, which will include the following:

- Summary of all public comments received for the HCBS-Autism program relating to the proposed transition plan, including any revisions as a result of the public comments
- Inventory and description of all HCBS-Autism settings
- How setting types meet or do not meet the federal HCBS settings requirements

#### Assessment Plan

- To complete assessments for HCBS Settings
- To identify areas of non-compliance that needs to be addressed
- To identify the number of individuals affected by the HCBS Settings Rule

#### A Compliance Plan

- To ensure the health and safety of participants who reside in locations that need to meet corrective action requirements for setting to come into compliance during the State's specified transition timeline
- To move individuals to compliant settings, if necessary
- In April, the KDADS, Medicaid operating agency, and KDHE, single State Medicaid agency, identified settings that should be reviewed for compliance with the HCBS Final Rule related to HCBS settings.

Over the first six months of the Transition Plan, KDADS will conduct provider assessments and develop a compliance summary from each provider type and identify areas of non-compliance for further review. This assessment will provide the basis for identifying, settings in compliance with the rule, settings requiring heightened scrutiny, and settings no longer qualifying for HCBS-Autism.

KDADS will assess all provider setting types to identify the scope of compliance and measure the impact on individual HCBS-Autism participants within 180 days of approval of the Transition Plan. The assessment will identify non-compliant settings and barriers to achieving compliance that require additional time to address. The assessment will also identify settings which are deemed ineligible by the new rule for which relocation of HCBS participants will be required. Kansas will use self-assessments, attestations, policy and record review, participant and provider interviews, observations, and other

tools to determine compliance with respect to the new rule.

- Non-residential settings will be reassessed if additional guidance from CMS warrants more information to determine compliance with the new rule. Non-residential settings will be assessed pending CMS additional guidance and within 90 days of approval of the Transition Plan.
- Quality Management Specialists (QMS), Health Facility Surveyors, and MCO Care Coordinators will assist the State in identifying compliance related issues through normally occurring interactions, and targeted reviews when heightened scrutiny is determined appropriate or when settings are determined likely ineligible for HCBS. Additional protocols will be added to existing quality review materials as part of ongoing compliance and quality assurance upon approval or advisement by CMS.
- HCBS settings results will be provided within 60 days of the date of assessment. Non-compliant settings will be asked to participate in Focus Groups following the completion of statewide assessment period. The Focus Groups will identify areas and reasons of non-compliance and additional guidelines and benchmarks for compliance with the Final Rule to ensure compliance of all HCBS settings. HCBS settings will be required to submit a plan of correction to address any identified areas of non-compliance which will be reviewed and accepted or rejected by the state.

In calendar year 2015, the State will review existing policies, regulations and statutes to identify barriers to compliance or conflicting information that hinders compliance. State law changes will be initiated to ensure compliance with HCBS Settings Rule and other elements of the CMS Final Rule, if appropriate.

Within 12 months of approval of the Transition Plan, the State will notify all HCBS settings and providers of their compliance with the new Final Rule. All settings that are currently in compliance will be identified and shared publicly with MCOs, stakeholders and consumers. HCBS-Autism settings that need additional time to come into compliance will be notified of non-compliance areas. KDADS will work with stakeholders to develop timelines and benchmarks for HCBS Setting Final Rule compliance within the shortest timeframe possible.

- Settings that have regulatory or statutory limitations will be notified of the process, plan and timeline to complete changes to regulation and state law to comply with the new Final Rule. This process for coming into compliance with the HCBS Final Setting Rule may take up to two (2) years to complete. Compliance steps will be required for the parts of the Final Rule that are not affected by regulatory or statutory limitations. Individuals and providers will be notified of the process, plan and timeline for all settings to come into compliance.
- The State will update all provider manuals, consumer handbooks, and guides to incorporate the Final Rule requirements within 90 days of completion of the Assessment and Compliance Review activities. Ongoing updates will be made as settings become compliant with the new rule or regulation and statutes changed. Non-compliant settings will be monitored by the quality assurance and program integrity group during the 5 year transition plan timeframe. Failure to comply by the established deadlines could result in a final determination that the setting is non-compliant.

For settings that are not compliant with the new Final Rule, the State will ensure appropriate transitions by working with stakeholders and community partners. Additional stakeholder input will be required to develop a comprehensive plan for transition by January 2016. However, all HCBS participants will be afforded education and information about their rights and responsibilities prior to a transition from a non-compliant setting to a compliant setting. The State will establish a transition policy for relocation or transition to compliant settings after public input and comment that will address the process for transition, ensure choice is provided, and identify timeframes for appropriate transition.

Over the next five years, the Kansas Department for Aging and Disability Services (KDADS) will ensure that all residential and non-residential locations where a person receives home and Community-based services (HCBS) through Medicaid allows individuals to be integrated in and have support for full access to services in the greater community, including opportunities to seek Employment and work in competitive integrated settings, to control personal resources, and to engage in community life in the same way as individuals not receiving Medicaid HCBS.

In HCBS settings will have:

- A lease or a written agreement with eviction and appeals rights
- Choice of settings and roommates based on their needs, preferences, and resources
- Choice of services and supports, and who provides
- Rights of privacy (lockable doors), dignity, respect, and freedom from coercion and restraint
- Right to control personal resources and make money in a job in the community
- Support for choice of daily activities, physical environment, and with whom to interact
- Freedom and support to control their own schedules, activities, and access food at any time
- Right and ability to have visitors of their choosing at any time
- A setting that is physically accessible, including ADA compliant
- Any limit or restriction supported by a specific assessed need, evaluated frequently, and be approved by the individual, parent or guardian

All provider controlled and owned residential and non-residential settings will be reviewed (regardless of license

requirements), within 180 days of approval of the Transition Plan to identify settings that do not meet the rule and need additional time to address. The other non-residential settings will be evaluated for compliance utilizing the regulations and toolkit provided by CMS. Noncompliance will be addressed on a case-by-case basis.

During 2015, KDADS will assess all HCBS Settings by June 30, 2015 to identify settings that comply with the HCBS Setting Rule and review state law and program policies that may need to be changed. KDADS will make changes to the Transition Plan in 2015 to set more specific timelines and benchmarks for compliance. By December 31, 2015, KDADS will identify all providers and individuals who may be affected by the changing rules and seek public input on timeframes and benchmarks. During 2016, KDADS will notify all HCBS-Autism providers of non-compliance areas, timelines for compliance and benchmarks for achieving compliance in the shortest period possible. KDADS may change the Transition Plan to ensure compliance with the HCBS Setting Rules based on the State's Transition Plan for Access, Compliance and Public Engagement.

#### Summary of Public Comments for Transition Plan

KDADS conducted Public Comments sessions to discuss the Statewide and HCBS specific Transition Plan for compliance with the HCBS Setting Final Rule. No comments were submitted regarding the HCBS-Autism specific Transition Plan. The HCBS-Autism Transition Plan was adopted to reflect the same time limitations modified in the Statewide Transition Plan based on public feedback. Modifications were also made to the HCBS-Autism specific Transition Plan following feedback from CMS.

Kansas offered various opportunities for securing public comments regarding the proposed work plan in response to the HCBS Settings Final Rule. The draft transition plans were posted online and a 30 day comment period was open between June 14, 2014 and July 15, 2014. Opportunities were provided through statewide conference calls and in-person public information session held in Lawrence, Topeka, and Wichita during the week of June 16-23, 2014. Additionally, the public was invited to submit comments through the HCBS general email address (HCBS-KS@kdads.ks.gov) or by mail. The purpose of the sessions was to meet two primary objectives:

- 1) To meet requirements for public comment period on the HCBS transition plan.
  - 2) To listen to comments from the public, record the comments, and submit a summary with the transition plan to CMS.
- Format for each session: Wichita State University Center for Community Support and Research (CCSR) staff opened the meeting, logistics.

KDADS state staff presented background information and draft transition work plan, including information regarding providers self-assessment surveys (due June 30). KDADS staff provided handouts on the statewide transition plan, HCBS Final Rule and FAQs relating to the final rule.

The facilitator, CCSR asked the following questions in each public sessions and conference call and provided opportunities for attendees to dialogue with each other in small groups, while KDADS listened to the discussions.

- What questions or understanding or clarification do you have?
- Related to the rule you just heard about, what is already working in Kansas? Where are we already complying? What do you like about home and community based settings?
- Based on what you heard today, what concerns do you have? What might need to be changed or improved to come into compliance with the rule? What do you think our biggest compliance issues will be?
- What other types of settings should the state consider?
- What other questions should the state be thinking about?

Comments are grouped by date and session type. CCSR collected general comments and confirmed attendees understanding of information being presented. Comments from a single person that covered multiple issues may have been divided into categories of facilitated questions as noted above; however, written comments are included verbatim. Comments received in-person has been paraphrased by the facilitator and by confirming with the person making comments the information was captured correctly.

The conferencing and in-person sessions attendance was well represented by providers from various settings such as long-term care facilities, group homes, private ICF-ID, other interested stakeholders and advocates.

Kansas hosted an additional week long public information session statewide during the week of August 18-22, 2014 to recap the HCBS Setting Final Rule. This additional public comment session also requested consumer and stakeholder feedback on the Department of Labor Rule, and proposed waiver amendments (Autism and Technology Assisted) programs and renewals (Frail Elderly, Intellectual Developmental Disability, Physical Disability and Traumatic Brain Injury) programs to be submitted 9/30/14. In these sessions, Kansas provided a short summary of the HCBS Final Rule, the

transition plan and what it means to consumers. The session was well attended by many HCBS consumers and family members, the overall message regarding the HCBS final rule and the transition plan was well received by the majority.

Consistently, Kansas heard consumer, family and provider concerns/ comments relating to the following examples:

- Will every setting receiving HCBS funding be assessed?
- Is the state expecting further guidance on person-centered planning and conflict-free case management?
- Do other settings where people go have to come under the HCBS final rule guidelines? Like the YMCA, or a cruise ship. Do those settings have to come into compliance?
- In a group home, does the “able to lock their own door” part apply to the whole house, or each individual?
- It might not be safe for every individual to be able to lock themselves behind a closed door. Will provision be made for those exceptions?
- Where it says that individuals should be able to access communication through text message and email, is it expected that providers would provide those tools, or that the individuals would?
- Where do we see this final ruling affecting individuals who live in group homes? They’ve lived there for 15-20 years; this is a family for them. They have a few hours of independent time during the day. Is this something where we’re going to have to encourage them to move?
- How vulnerable is too vulnerable to live alone in the community?
- Do all waivers have a full 5 years to get in compliance? Some appear to have only 12 months. Kansas will assess settings and may request 5 years for transitions.

The public feedback sessions provided Kansas with valuable information as we move into the next phase of the transition plan. Following the additional public comments sessions, Kansas will need to explore possible options to allow exceptions for individuals where the HCBS setting may be assessed out of compliance with the final rule and moving to an alternative setting may threaten the health and welfare of the person.

The facilitator (CCSR) collected and summarized the comments and information from in-person meetings, teleconferencing, and by email and provided a themed summary.

Kansas assures that the settings transition plan included with this waiver renewal will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. The State will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

### **Additional Needed Information (Optional)**

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Provide additional needed information for the waiver (optional):

N/A

### **Appendix A: Waiver Administration and Operation**

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

- The waiver is operated by the State Medicaid agency.**

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

- The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

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

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

## Appendix A: Waiver Administration and Operation

### 2. Oversight of Performance.

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

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

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

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

- Specifies that the SSMA is the final authority on compensatory Medicaid costs.
- Recognizes the responsibilities imposed upon the SSMA as the agency authorized to administer the Medicaid program, and the importance of ensuring that the SSMA retains final authority necessary to discharge those responsibilities.
- Requires the SSMA approve all new contracts, MOUs, grants or other similar documents that involve the use of Medicaid funds.
- Notes that the agencies will work in collaboration for the effective and efficient operation of Medicaid health care programs, including the development and implementation of all program policies, and for the purpose of compliance with all required reporting and auditing of Medicaid programs.
- Requires the SSMA to provide KDADS with professional assistance and information, and both agencies to have designated liaisons to coordinate and collaborate through the policy implementation process.
- Delegates to KDADS the authority for administering and managing certain Medicaid-funded programs, including those covered by this waiver application.
- Specifies that the SSMA has final approval of regulations, 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 KDADS furnishing information, recommendations and participation. (The submission of this waiver application is an operational example of this relationship. Core concepts were developed through collaboration among program and operations staff from both the SSMA and KDADS; functional pieces of the waiver were developed collectively by KDHE and KDADS staff; and

overview/approval of the submission was provided by the SSMA, after review by key administrative and operations staff and approval of both agencies' leadership.)

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

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

Kansas Department of Health and Environment, as the single state Medicaid agency, has oversight responsibilities for all Medicaid programs, including direct involvement or review of all functions related to HCBS waivers. In addition, under the KanCare program, the HCBS waiver programs have merged into comprehensive managed care, KDHE has oversight of all portions of the program and the KanCare MCO contracts, and collaborates with KDADS regarding HCBS program management, including those items identified in part (a) above. The key component of that collaboration is through the interagency monitoring team, an important part of the overall state's KanCare Quality Improvement Strategy, which provides quality review and monitoring of all aspects of the KanCare program – engaging program management, contract management, and financial management staff from both KDHE and KDADS.

The services in this waiver are part of the state's KanCare comprehensive Medicaid managed care program. The quality monitoring and oversight for that program, and the interagency monitoring (including the SSMA's monitoring of delegated functions to the Operating Agency) are guided by the KanCare Quality Improvement Strategy. A critical component of that strategy is the engagement of the interagency monitoring team, which will bring together leadership, program management, contract management, fiscal management and other staff/resources to collectively monitor the extensive reporting, review results and other quality information and data related to the KanCare program and services. Because of the managed care structure, and the integrated focus of service delivery/care management, the core monitoring processes – including interagency monitoring team meetings – are on a quarterly basis. While continuous monitoring will be conducted, including on monthly and other intervals, the aggregation, analysis and trending processes are built around that quarterly structure.

## 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.*

KDADS has contracted with one provider who acts as the entry point for the Waiver services across the state. The contracted entity (KVC) conducts the level of care determination utilizing the state approved functional eligibility instrument (FEI). The provider also disseminates information to potential children/families, makes referrals to appropriate providers, and conducts assessments and re-assessments.

The state's contracted Managed Care Organizations (MCO) are responsible for ensuring paid support staff or other professionals carry out the plan of care that supports the child's functional development and inclusion in the community. The state's contracted MCOs conduct plan of care development and related service authorizations, develop and review service plans, assist with utilization management, conduct provider

credentialing, provider manual, and other provider guidance; and participate in the comprehensive state quality improvement strategy for the KanCare program including this waiver.

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

## Appendix A: Waiver Administration and Operation

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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:

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

## Appendix A: Waiver Administration and Operation

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

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

The KanCare Quality Improvement Strategy and interagency agreements/monitoring teams ensure that the entities contracting with KDADS (the Waiver Operating Agency) are operating within the established parameters. These parameters include CMS rules/guidelines, the approved KanCare managed care contracts and related 1115 waiver, Kansas statutes and regulations, and related policies. Included in the QIS is an ongoing assessment of the results of onsite monitoring and in-person reviews with a sample of HCBS waiver participants. The interagency monitoring team meets quarterly.

## Appendix A: Waiver Administration and Operation

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

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency.

*Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

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

## Appendix A: Waiver Administration and Operation

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

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

**a. Methods for Discovery: Administrative Authority**

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

**i. Performance Measures**

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

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

*Where possible, include numerator/denominator.*

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

**Performance Measure:**

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

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Meeting minutes**

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

**Data Aggregation and Analysis:**

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

**Performance Measure:**

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

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Quality Review Reports**

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

	<input type="text"/>	
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**Data Aggregation and Analysis:**

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

**Performance Measure:**

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

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

**Presentation of waiver policy changes**

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

	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

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

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Number of waiver amendments and renewals**

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

<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

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

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

Data gathered by KDADS Regional Staff during the Quality Survey Process is compiled quarterly for evaluation and trending to identify areas for improvement. Upon completion of identified areas of improvement this information is compiled into reports and shared both internally and externally, including with KDHE. As part of the KanCare program, staff of the three MCOs are engaged with state staff to

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

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

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

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

Monitoring and survey results are compiled, trended, reviewed, and disseminated consistent with protocols identified in the statewide quality improvement strategy. Each provider receives annual data trending which identifies Provider specific performance levels related to statewide performance standards and statewide averages. Corrective Action Plan requests, technical assistance and/or follow-up to remediate negative trending are included in annual reports where negative trending is evidenced.

ii. Remediation Data Aggregation

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

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

**c. Timelines**

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

- No**
- Yes**

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

## Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input type="checkbox"/> Aged or Disabled, or Both - General					
	<input type="checkbox"/>	Aged			<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)			
	<input type="checkbox"/>	Disabled (Other)			
<input type="checkbox"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input checked="" type="checkbox"/> Intellectual Disability or Developmental Disability, or Both					
	<input checked="" type="checkbox"/>	Autism	0	5	<input type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability			<input type="checkbox"/>
	<input type="checkbox"/>	Intellectual Disability			<input type="checkbox"/>
<input type="checkbox"/> Mental Illness					
	<input type="checkbox"/>	Mental Illness			
	<input type="checkbox"/>	Serious Emotional Disturbance			

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

To be eligible for the HCBS/Autism Waiver services, the child must have a diagnosis of Autism Spectrum Disorder, (ASD) including Autism, Asperger Syndrome, and Other Pervasive Developmental Disorder-Not Otherwise Specified from a Medical Doctor or Ph.D. Psychologist using an approved autism specific screening tool. The approved screening tools are;

- \*CARS - Childhood Autism Rating Scale
- \*GARS - Gilliam Autism Rating Scale
- \*ADOS - Autism Diagnostic Observation Scale
- \*ADI - Autism Diagnostic Interview-Revised
- \*ASDS - Asperger Syndrome Diagnostic Scale
- \*Other Autism specific tools as approved by KDADS

Once the child has received a diagnosis of ASD they must also meet the level of care (functional) eligibility guidelines utilizing the state approved functional eligibility instrument.

- 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:*

If the child will require additional waiver services after exiting the HCBS/Autism Waiver the KanCare MCO will assist the child/family in gaining access to other waiver services. The family may choose to transition the child to the HCBS/IDD waiver, providing the established criteria for the waiver is met by the child. The KanCare MCO will contact the appropriate agency 6 months prior to the child transitioning off the HCBS/Autism waiver to develop a transition plan to the appropriate waiver.

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

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

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

- No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

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

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

Specify the percentage:

- Other**

*Specify:*

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

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

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

- The following dollar amount:**

Specify dollar amount:

The dollar amount (select one)

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

Specify the formula:

- May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.
- The following percentage that is less than 100% of the institutional average:

Specify percent:

- Other:

Specify:

## Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

- Other safeguard(s)

Specify:

## Appendix B: Participant Access and Eligibility

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

- a. Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to

CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

**Table: B-3-a**

Waiver Year	Unduplicated Number of Participants
Year 1	80
Year 2	80
Year 3	80
Year 4	80
Year 5	80

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	65
Year 2	65
Year 3	65
Year 4	65
Year 5	65

**Appendix B: Participant Access and Eligibility**

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

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

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

Purpose(s) the State reserves capacity for:

Purposes	
Military Inclusion	
Temporary Institutional Stay	

## Appendix B: Participant Access and Eligibility

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

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

Military Inclusion

**Purpose** (describe):

The State reserves capacity for dependents and immediate family members of military personnel who have been determined program eligible to bypass waitlist upon approval by KDADS. In the event Kansas instituted a waitlist, individuals who have been determined to meet the established Autism waiver criteria will be allowed to bypass the waitlist and access services.

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

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

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

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

## Appendix B: Participant Access and Eligibility

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

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

Temporary Institutional Stay

**Purpose** (describe):

The state reserves capacity to maintain continued waiver eligibility for participants who enters into an institution such as hospitals or ICF/ID for the purpose of seeking treatment for acute, habilitative or rehabilitative conditions on a temporary basis less than 90 days. Temporary stay is defined as a stay that includes the month of admission and two months following admission. Consumers that remain in the institution following the two month allotment will be terminated from the HCBS program. The consumer can choose to reapply for services at a later date and will be reinstated if the consumer meets program eligibility requirements or placed on a waiting list if applicable.

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

This amount is a projected reserved capacity

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

Waiver Year	Capacity Reserved
Year 1	2
Year 2	2

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

## Appendix B: Participant Access and Eligibility

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

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

- The waiver is not subject to a phase-in or a phase-out schedule.**
- The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

**e. Allocation of Waiver Capacity.**

*Select one:*

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

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

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

To be eligible for the HCBS/Autism Waiver services, the child must have a diagnosis of Autism Spectrum Disorder, (ASD) including Autism, Asperger Syndrome, and Other Pervasive Developmental Disorder-Not Otherwise Specified. The diagnosis of ASD must be made by a Medical Doctor or PhD Psychologist using an approved autism specific screening tool. The approved screening tools are;

- \*CARS - Childhood Autism Rating Scale
- \*GARS - Gilliam Autism Rating Scale
- \*ADOS - Autism Diagnostic Observation Scale
- \*ADI - Autism Diagnostic Interview-Revised
- \*ASDS - Asperger Syndrome Diagnostic Scale
- \*Other Autism specific tools as approved by KDADS

Once the child has received a diagnosis of ASD they must also meet the level of care (functional) eligibility guidelines utilizing the state approved functional eligibility instrument. Entrance to the waiver is determined on a first come first serve basis. The date and time request for waiver services received at KDADS will be the determining factor. The number of eligible entrants into the program is limited to the number of waiver capacity allowed by funding.

The Autism Program Manager maintains a statewide "Proposed Recipient List" of those children who have a diagnosis of ASD, request Autism Waiver services, and have completed the necessary form indicating the name of the child, diagnosis, address, date of birth, phone number, and name of parent/guardian. The form can be taken to the local Department for Children and Families (DCF) office and date/time stamp or fax to the Autism Program Manager. The date/timed stamped and/or faxed date/time will be the determining factor for the first come first serve

policy. The "Proposed Waiver Recipient" list is being utilized to determine when a child will be offered services as HCBS/Autism slot becomes available.

## Appendix B: Participant Access and Eligibility

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

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

## Appendix B: Participant Access and Eligibility

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

a.

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

- §1634 State  
 SSI Criteria State  
 209(b) State

2. **Miller Trust State.**

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

- No  
 Yes

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

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

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

*Select one:*

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

Specify percentage:

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

Specify:

Parents and other caretaker relatives (42 CFR 435.110)

---

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

- A special income level equal to:

Select one:

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

Specify percentage:

- A dollar amount which is lower than 300%.

Specify dollar amount:

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

Select one:

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

Specify percentage amount:

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

Specify:

## Appendix B: Participant Access and Eligibility

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

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

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

*Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.*

- Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses spousal post-eligibility rules under §1924 of the Act. Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.**

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

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

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

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

## Appendix B: Participant Access and Eligibility

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

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

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

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

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

- The following standard included under the State plan**

*Select one:*

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

(*select one*):

- 300% of the SSI Federal Benefit Rate (FBR)**

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

Specify the percentage:

- A dollar amount which is less than 300%.**

Specify dollar amount:

- A percentage of the Federal poverty level**

Specify percentage:

- Other standard included under the State Plan**

*Specify:*

- The following dollar amount**

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

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

*Specify:*

- Other**

*Specify:*

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

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

---

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

---

- Not Applicable (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:*



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

---

- Not Applicable (see instructions)**
- AFDC need standard**

- Medically needy income standard**  
 **The following dollar amount:**

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

- The amount is determined using the following formula:**

Specify:

- Other**

Specify:

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

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

Select one:

- Not Applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*  
 **The State does not establish reasonable limits.**  
 **The State establishes the following reasonable limits**

Specify:

## Appendix B: Participant Access and Eligibility

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

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

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

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

## Appendix B: Participant Access and Eligibility

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

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

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

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

---

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

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

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

---

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

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

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

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

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

---

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

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

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

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

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

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

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

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## **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:*

- 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:

\*\*\*Must meet the qualifications specified by Pearson Assessments, as a level 3 user:

- "User has a licensure to practice psychology independently, or User has completed a doctoral (or in some cases masters) degree program in one of the fields of study indicated for the test that included training (through coursework and supervised practical experience) in the administration and interpretation of clinical instruments. If neither of these qualifications are met, Users must provide proof that they have been granted the right to administer tests at this level in their jurisdiction".

\*Must be able to provide proof of professional liability insurance and automobile liability insurance coverage

\*Must complete KDADS approved training criteria, and

\*Must successfully pass Kansas Bureau of Investigation (KBI), Adult Protective Services (APS), Child Protective Services (CPS), Nurse Aid, 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.

A qualified Functional Eligibility Specialist conducts the level of care (functional eligibility) assessment of the child who is applying for waiver services within five (5) working days of the referral, unless a different timeframe is

requested by the participant/family applying for services or their legal representative, if appropriate.

The child must have a total score or a score on any two elements of the Adaptive Areas (Communication, Daily Living skills, Socialization, and Motor skills) of two standard deviations below the mean of 100 (i.e., a score of 70 or below) in order to be eligible for the waiver.

Or

A total score or a score on any two elements of the Adaptive Areas (Communication, Daily Living Skills, Socialization and Motor skills) of one standard deviation below the mean of 100 (score of 71-85). This prompts the assessor to review the scores on the Maladaptive Behaviors (internal, external or total). If the Maladaptive Score on the internal, external, or total is clinically significant, a v-scale score of 21-24, the child is eligible for the Waiver.

The Functional Eligibility Instrument (FEI) measures the personal and social skills of individuals from birth through adulthood. Because adaptive behavior refers to a participant's typical performance of the day-to-day activities required for personal and social sufficiency, these scales assess what a person actually does, rather than what he or she is able to do. The FEI assesses adaptive behavior in four domains: Communication, Daily Living Skills, Socialization, and Motor Skills. It also provides a composite score that summarizes the participant's performance across all four domains.

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 Community Mental Health Center Screening Form is utilized to screen for a variety of intensive inpatient psychiatric services. The form includes information on presenting problem, risk factors, clinical impressions, and inpatient criteria. The form is not based on a standardized tool or assessment, but solely on the self-report of the participant or family and the clinical judgment of qualified mental health practitioner.

The FEI is the Autism Waiver functional eligibility tool (LOC Determination) to be utilized to determine functional eligibility). The FEI is a measurement of personal and social skills from birth to adulthood. The FEI focuses on four adaptive domains and one maladaptive domain: within all of the domains there are sub-domains which allow for greater in-depth holistic approach in developing the plan of care. The following domains and sub-domains are: 1) communication, (subdomain-receptive, expressive, and written), 2) Daily Living Skills (sub-domain-personal, domestic, and community), 3) Socialization (subdomain- interpersonal relationships, play and leisure time, and coping skills), 4) Motor Skills (subdomain-fine and gross), 5) Maladaptive Behavior Index (subdomain-internalizing, externalizing, and other).

Although the Mental Health Screening Form and the FEI are comparable in addressing the areas (domains) of a child's life the State of Kansas choose the FEI because it goes into greater details in each domain which in turn allows the assessor to identify the specific problematic areas a child is experiencing. This is accomplished because the FEI is a standardized tool; it guides the assessor throughout all domains by having set specific questions. The assessor must rate each question according to the following rating scale;

- 2 (behavior is usually or habitually performed),
- 1 (sometimes or partly performed),
- 0 (never performed).

In addition there is a code "N" for instances when the child has never had the opportunity to perform the activity and or behavior. A code "DK" is when the caregiver does not know if the child preformed the activity and or experienced the behavior. It also provides a composite score that summarized the individual's performance across the domains. Therefore, Kansas views the FEI to not only be comparable or equivalent to the Mental Health Screening Instrument but actually exceeds it by identifying and addressing the child's specific needs.

- 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 initial Level of Care evaluation. The Functional Eligibility Specialist completes the annual evaluation utilizing the FEI to ensure the child continues to meet eligibility criteria.

There are two areas of eligibility a participant must meet: level of care (functional) and financial eligibility

KDADS has contracted with one provider who will administer the FEI in order to determine the level of care (LOC) for functional eligibility and assist the child/family in obtaining eligibility for waiver services. The following criteria apply for waiver eligibility:

- 1) Age- at the time of entrance to the waiver a child must be between the ages of zero (0) through age five (5) years.
- 2) Diagnosis: Receive a diagnosis of Autism or Autism Spectrum Disorder (ASD) from a Licensed Medical Doctor or Ph.D. Psychologist using an approved Autism specific screening tool.
- 3) LOC determination: A functional assessment using the FEI must be completed and the child must meet the established scoring criteria in order to determine functional eligibility.
- 4) A child must be determined as likely to need inpatient psychiatric facility level of care in the absence of waiver services.
- 5) Family Choice form: Documentation to support Parents/Guardians choice of the waiver
- 6) Annual Reevaluation - The need for HCBS Autism Waiver services is re-evaluated (face to face) at a minimum on an annual basis but also any time the family feels it is appropriate, as needs change, and/or as goals are completed.
- 7) A child's services shall be limited to three years unless medically necessary, for reason of medical necessity, services may be extended for one year with approval of the review team.

Review team will consist of; HCBS/Autism Program Manager, a Therapist or an individual who works with autistic children, and an Autism Specialist that is not directly involved with the child/family requesting the exception.

Notice of Action- When a child is found functionally eligible or ineligible during the initial evaluation or the annual re-evaluation the child/family will receive a Notice of Action advising them of the status of functional eligibility.

All functional eligibility documentation including the initial evaluation, the annual re-evaluation, freedom of choice and the notice of action are to be maintained in the child's case file.

- 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*):

Records are maintained by the provider responsible for performing the initial eligibility determination and annual reevaluation. 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.

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

Records are maintained by the provider responsible for performing the initial eligibility determination and annual reevaluation. 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. It will also be maintained in the State of Kansas Medicaid Management Information System(MMIS) .

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

### Quality Improvement: Level of Care

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

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

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

**i. Sub-Assurances:**

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

**Performance Measures**

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

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

**Performance Measure:**

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

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Operating Agency's data systems and Managed Care Organizations (MCOs) encounter data**

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<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95%
<input checked="" type="checkbox"/> <b>Other</b> Specify: Contracted assessors and Managed Care Organizations (MCOs)	<input checked="" type="checkbox"/> <b>Annually</b>	<input checked="" type="checkbox"/> <b>Stratified</b> Describe Group: Proportionate by MCO
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify: Contracted assessors participate in analysis of this measure's results as determined by the State operating agency	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

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

**Performance Measures**

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

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

**Performance Measure:**

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

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Operating agency's data systems: "Kansas Assessment Management Information (KAMIS) System or its related web applications"**

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95%
<input checked="" type="checkbox"/> <b>Other</b> Specify: Contracted assessors	<input type="checkbox"/> <b>Annually</b>	<input checked="" type="checkbox"/> <b>Stratified</b> Describe Group: Proportionate by MCO
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Contracted assessors participate in analysis of this measure's results as determined by the State operating agency	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

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

**Performance Measures**

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

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

**Performance Measure:**

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

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Assessor and assessment records**

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	

		<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> <b>Other</b> Specify: Contracted assessors	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify: Contracted assessors participate in analysis of this measure's results as determined by the State operating agency	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

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

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Record reviews**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95%
<input checked="" type="checkbox"/> <b>Other</b> Specify: Contracted assessors	<input type="checkbox"/> <b>Annually</b>	<input checked="" type="checkbox"/> <b>Stratified</b> Describe Group: Proportionate by MCO
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify: Contracted assessors participate in analysis of this measure's results as determined by the State operating agency	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify:

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

**Performance Measure:**

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

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Reocrd reviews**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95%
<input checked="" type="checkbox"/> <b>Other</b> Specify: Contracted assessors	<input type="checkbox"/> <b>Annually</b>	<input checked="" type="checkbox"/> <b>Stratified</b> Describe Group: Proportionate by MCO
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Contracted assessors participate in analysis of this measure's results as determined by the State operating agency	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

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

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

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

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

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

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

**ii. Remediation Data Aggregation**

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

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

Responsible Party( <i>check each that applies</i> ):	Frequency of data aggregation and analysis ( <i>check each that applies</i> ):
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

**c. Timelines**

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

**No**

**Yes**

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

## Appendix B: Participant Access and Eligibility

### B-7: Freedom of Choice

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

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

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

Kansas continues to offer families a choice between an Inpatient psychiatric facility for individuals less than 21 years of age as provided in 42CFR 440.160 and Home Community Based Services (HCBS). Families shall be informed of any feasible alternative available under the waiver, and given the choice of either inpatient psychiatric facility or home and community-based services [42 CFR 441.302(d)]. Due to the age, numbers served and targeted population for this waiver, if a family should choose an Inpatient psychiatric facility rather than HCBS, Kansas, through the managed care delivery model, enters into a contract with an out of state provider to provide services for that child.

After the child is determined to be eligible for the HCBS/Autism waiver services, the child/family receives:

- 1) A copy of the form(s) used to document freedom of choice and to offer a fair hearing;
- 2) A description of the agency's procedure(s) for informing eligible children (or their legal representatives) of the feasible alternatives available under the waiver;
- 3) A description of the State's procedures for allowing participants to choose either institutional or home and community-based services; and
- 4) A description of how the participant (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E.
- 5) Because of its importance, the provider is responsible for providing or explaining the freedom of choice form to the child/family.

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

The Family Choice Document (freedom of choice) form, Rights and Responsibilities, and Request for a Fair Hearing is maintained in the child's case file at the individual provider/agency responsible for determining eligibility per K.A.R 30-60-57. A child's/family members' signature on the Family Choice Document indicates and ensures they have been informed of the options available.

## Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

## Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	Respite Care		
Other Service	Family Adjustment Counseling		
Other Service	Parent Support and Training (peer to peer) Provider		

## 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):**

Respite Care

**HCBS Taxonomy:****Category 1:****Sub-Category 1:**

10 Other Mental Health and Behavioral Services ~~100~~30 crisis intervention 

**Category 2:****Sub-Category 2:**



**Category 3:****Sub-Category 3:**



**Category 4:****Sub-Category 4:**



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

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

**Service Definition (Scope):**

Respite Care provides temporary direct care and supervision for the child. The primary purpose is relief to families/caregivers of a child with an autism spectrum disorder. The service is designed to help meet the needs of the primary caregiver as well as the identified child. Normal activities of daily living are considered content of the service when providing respite care, and include support in the home, after school, or at night.

Transportation to and from school/medical appointments/ or other community based activities, and/or any combination of the above is included in the rate paid to providers of this services.

FFP is not claimed for the cost of room and board.

Respite care does not duplicate any other Medicaid State Plan Service or service otherwise available to recipient at no cost.

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

- 1) Respite Care services are available to participants who have a family member who serves as the primary care giver who is not paid to provide any HCBS/ Autism service for the child.
- 2) Respite care may not be provided by a parent of the child.
- 3) Respite Care cannot be provided to an individual who is an inpatient of a hospital or State Mental Hospital when the inpatient facility is billing Medicaid, Medicare and/ or private insurance.
- 4) Respite Services are subject to prior approval, and must be intended to achieve the goals or objectives identified in the child's individualized plan of care.
- 5) Respite care is provided in planned or emergency segments and may include payment during the individuals sleep time
- 6) Respite is limited to 168 hours per calendar year.

**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	Respite Care Provider
Agency	Community Service Provider, (CSP) and Community Mental Health Center, (CMHC)

**Appendix C: Participant Services**

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

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

**Provider Category:**

Individual ▾

**Provider Type:**

Respite Care Provider

**Provider Qualifications**

**License** (specify):

**Certificate** (specify):

**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 KDADS training and professional development requirements; maintenance of clear background as evidenced through background checks of; KBI, APS, CPS, Nurse Aide Registry, and Motor Vehicle screen.

Any provider found identified to have been substantiated for prohibited offenses as listed in KSA 39-970 & 65-5117 is not eligible for reimbursement of services under Medicaid funding.

High School Diploma or equivalent,

Eighteen years of age or older,

Must meet family's qualifications,

Must reside outside of child's home,

Completion of the state approved training curriculum, and

Medicaid Enrolled Provider

MCO contracted provider

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

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

**Frequency of Verification:**

Kansas provides monitoring and oversight of MCO's verification of HCBS-Autism provider qualifications. This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.

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

**Service Type: Statutory Service**

**Service Name: Respite Care**

**Provider Category:**

Agency

**Provider Type:**

Community Service Provider, (CSP) and Community Mental Health Center, (CMHC)

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

Community Service Provider will be licensed by KDADS,  
Community Mental Health Center will be licensed under K.A.R. 30-60-1

**Certificate (specify):**

**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 KDADS training and professional development requirements; maintenance of clear background as evidenced through background checks of; KBI, APS, CPS, Nurse Aide Registry, and Motor Vehicle screen.

Any provider found identified to have been substantiated for prohibited offenses as listed in KSA 39-970 & 65-5117 is not eligible for reimbursement of services under Medicaid funding.

High School Diploma or equivalent,

Eighteen years of age or older,

Must meet family's qualifications,

Must reside outside of child's home,

Completion of the state approved training curriculum, and

Medicaid Enrolled Provider

MCO contracted provider

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

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

**Frequency of Verification:**

Kansas provides monitoring and oversight of MCO's verification of HCBS-Autism provider qualifications. This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.

## Appendix C: Participant Services

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

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

**Service Type:**

Other Service 

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

**Service Title:**

Family Adjustment Counseling

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

10 Other Mental Health and Behavioral Services 10060 counseling 

**Category 2:**

**Sub-Category 2:**



**Category 3:**

**Sub-Category 3:**



**Category 4:**

**Sub-Category 4:**



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

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

**Service Definition (Scope):**

Counseling can be provided to the family members of a child with an autism spectrum disorder in order to guide and help them cope with the child's illness and the related stress that accompanies the initial understanding of the diagnosis and the ongoing continuous, daily care required by the child with an autism spectrum disorder. Enabling the family to manage this stress improves the likelihood that the child with the disorder will continue to be cared for at home, thereby preventing premature and otherwise unnecessary institutionalization. Family Adjustment Counseling offers the family a mechanism for expressing emotions associated with the comprehension of the disorder and asking questions about the disorder in a safe and supporting environment. When acceptance of the disorder can be achieved the family is prepared to support the child on an ongoing basis. The service is provided by a Licensed Mental Health Professional (LMHP).

For the purposes of this service, "family" is defined as unpaid persons who live with or provide care to a person served on the waiver, and may include a parent, step parent, legal guardian, siblings, relatives, or grandparents. Services may be provided individually or in a group setting, are subject to prior approval, and must be intended to achieve the goals or objectives identified in the child's individualized plan of care.

Family Adjustment Counseling 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:**

Family Adjustment Counseling is limited to 12 hours per calendar year.

Services are subject to prior approval, and must be intended to achieve the goals or objectives identified in the child’s individualized behavioral plan of care.

Group setting cannot consist of more than 3 families.

The group membership requirement for Family Adjustment Counseling is that members each have a family member with a diagnosis of ASD.

Families must agree to a group setting

Delivery of this service may occur via telemedicine, telehealth or other modes of video distance monitoring methods that adhere to all required HIPPA guidelines and meet the state standards for telemedicine delivery methods. This service delivery model is subject to state program manager approval. A request submitted for this exception must include, at a minimum, three (3) written statements from service providers in at least a 50 mile radius declining to provide services because the child/family resides in a location that is so remote or far away that the provider does not have staff to meet with the child on a continual and/or intermittent basis as needed.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Family Adjustment Counseling Provider
Agency	Licensed Mental Health Professional, Community Mental Health Center

**Appendix C: Participant Services**

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

**Service Type:** Other Service  
**Service Name:** Family Adjustment Counseling

**Provider Category:**

Individual ▾

**Provider Type:**

Family Adjustment Counseling Provider

**Provider Qualifications**

**License** (specify):

a Licensed Mental Health Professional (LMHP) must hold a current license to practice in the state of Kansas by the Kansas Behavioral Sciences Regulatory Board, K.A.R. 28-5-564

**Certificate** (specify):

**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 KDADS training and professional development requirements; maintenance of clear background as evidenced through background checks of; KBI, APS, CPS, Nurse Aid Registry, and Motor vehicle screen.

Any provider found identified to have been substantiated for prohibited offenses as listed in KSA 39-970 & 65-5117 is not eligible for reimbursement of services under Medicaid funding.

Maintain an ongoing collaborative relationship with the Autism Specialist beginning at the time of referral.

Medicaid Enrolled Provider

MCO contracted provider

#### **Verification of Provider Qualifications**

##### **Entity Responsible for Verification:**

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

##### **Frequency of Verification:**

Kansas provides monitoring and oversight of MCO's verification of HCBS-Autism provider qualifications. This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.

## **Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Family Adjustment Counseling**

#### **Provider Category:**

Agency 

#### **Provider Type:**

Licensed Mental Health Professional, Community Mental Health Center

#### **Provider Qualifications**

##### **License (specify):**

-A Licensed Mental Health Professional (LMHP) must hold a current licensed to practice in the State of Kansas by the Kansas Behavioral Sciences Regulatory Board, K.A.R.28-5-564

-Community Mental Health Center must operate and function within regulatory guidelines set forth in K.A.R. 30-60-1

##### **Certificate (specify):**

##### **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 KDADS training and professional development requirements; maintenance of clear background as evidenced through background checks of; KBI, APS, CPS, Nurse Aid Registry, and Motor vehicle screen.

Any provider found identified to have been substantiated for prohibited offenses as listed in KSA 39-970 & 65-5117 is not eligible for reimbursement of services under Medicaid funding.

Medicaid Enrolled Provider

MCO contracted provider

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

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

**Frequency of Verification:**

Kansas provides monitoring and oversight of MCO's verification of HCBS-Autism provider qualifications. This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.

**Appendix C: Participant Services****C-1/C-3: Service Specification**

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

**Service Type:**

Other Service 

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

**Service Title:**

Parent Support and Training (peer to peer) Provider

**HCBS Taxonomy:****Category 1:****Sub-Category 1:**

10 Other Mental Health and Behavioral Services  10090 other mental health and behavioral services 

**Category 2:****Sub-Category 2:**



**Category 3:****Sub-Category 3:**



**Category 4:****Sub-Category 4:**



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

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

**Service Definition (Scope):**

Parent Support and Training is designed to provide the training and support necessary to ensure engagement and active participation of the family in the treatment process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. Support and Training is provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the child. This involves assisting the family with the acquisition of knowledge and skills necessary to understand and address the specific needs of the child in relation to their autism spectrum disorder and

treatment; and development and enhancement of the family's specific problem-solving skills, coping mechanisms, and strategies for the child's symptom/behavior management.

For the purposes of this service, "family" is defined as persons who live with or provide care to a child served on the waiver, and may include a parent, step parent, legal guardian, siblings, relatives, grandparents, or foster parents. Services may be provided individually or in a group setting, are subject to prior approval, and must be intended to achieve the goals or objectives identified in the child's individualized plan of care.

Parent Support and Training 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:**

Parent Support and Training is limited to 30 hours per calendar year.

Services are subject to prior approval, and must be intended to achieve the goals or objectives identified in the child's individualized behavioral plan of care.

Group settings cannot consist of more than 3 families.

The group membership requirement for Parent Support is that members each have a family member with a diagnosis of ASD.

Families must agree to a group setting

Delivery of this service may occur via telemedicine, telehealth or other modes of video distance monitoring methods that adhere to all required HIPPA guidelines and meet the state standards for telemedicine delivery methods. This service delivery model is subject to state program manager approval. A request submitted for this exception must include, at a minimum, three (3) written statements from service providers in at least a 50 mile radius declining to provide services because the child/family resides in a location that is so remote or far away that the provider does not have staff to meet with the child on a continual and/or intermittent basis as needed.

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

- Participant-directed as specified in Appendix E  
 Provider managed

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Parent Support Provider
Agency	Community Service Providers, (CSP) and Community Mental Health Centers (CMHC)

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Parent Support and Training (peer to peer) Provider**

**Provider Category:**

Individual ▼

**Provider Type:**

Parent Support Provider

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**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 KDADS training and professional development requirements; maintenance of clear background as evidenced through background checks of; KBI, APS, CPS, Nurse Aide Registry, and Motor Vehicle screen. Any provider found identified to have been substantiated for prohibited offenses as listed in KSA 39-970 & 65-5117 is not eligible for reimbursement of services under Medicaid funding.

\*High School Diploma or equivalent

\*Twenty-one years of age or older

\*Completion of parent support training or other approved training curriculum.

\*Must have three years of direct care experience with a child with an autism spectrum disorder, Or be the parent of a child with an autism spectrum disorder

\*Medicaid Enrolled Provider

\* MCO contracted provider

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

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

**Frequency of Verification:**

Kansas provides monitoring and oversight of MCO's verification of HCBS-Autism provider qualifications. This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Parent Support and Training (peer to peer) Provider****Provider Category:**Agency **Provider Type:**

Community Service Providers, (CSP) and Community Mental Health Centers (CMHC)

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

Community Service Providers are licensed by KDADS

Community Mental Health Center will be licensed under K.A.R. 30-60-1

**Certificate (specify):**

**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 KDADS training and professional development requirements; maintenance of clear background as evidenced through background checks of; KBI, APS, CPS, Nurse Aide Registry, and Motor Vehicle screen. Any provider found identified to have been substantiated for prohibited offenses as listed in KSA 39-970 & 65-5117 is not eligible for reimbursement of services under Medicaid funding.

\*High School Diploma or equivalent

\*Twenty-one years of age or older

\*Completion of parent support training or other approved training curriculum.

\*Must have three years of direct care experience with a child with an autism spectrum disorder, Or be the parent of a child with an autism spectrum disorder.

\*Medicaid Enrolled provider and MCO contracted provider

#### **Verification of Provider Qualifications**

##### **Entity Responsible for Verification:**

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

##### **Frequency of Verification:**

Kansas provides monitoring and oversight of MCO's verification of HCBS-Autism provider qualifications. This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.

## **Appendix C: Participant Services**

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

**b. Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

**Not applicable** - Case management is not furnished as a distinct activity to waiver participants.

**Applicable** - Case management is furnished as a distinct activity to waiver participants.

*Check each that applies:*

**As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*

**As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*

**As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*

**As an administrative activity.** *Complete item C-1-c.*

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

## **Appendix C: Participant Services**

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### **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 contactor / sub contactor and /or provider must complete a KBI, APS, CPS, Nurse Aide Registry, and motor vehicle screen upon the hiring of the following providers of services:

- Eligibility Determination (Functional Eligibility Specialist)
- Respite Care Provider
- Parent Support Specialist Provider
- Family Adjustment Counseling Provider

The contactor / sub contactor and /or provider must provide evidence that required standards have been met at the time of renewing their license. This standard can be reviewed by KDADS regional field staff at the time of their reviews and sooner if a potential problem is identified. At any time deemed appropriate by KDADS, a certification may be formally resurveyed by KDADS to determine whether the licensee continues to be in compliance with the requirements, per K.A.R. 30-60-6

A single provider must provide the above documentation along with qualifications to the MCO and receive prior authorization before the delivery of services.

- 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 Department for Children and Families (DCF) child abuse, adult abuse and nurses aid registries. DCF Children and Adults Services maintain the registries for all confirmed perpetrators.

- Functional Eligibility Determination (Eligibility Specialist)
- Respite Care Provider
- Parent Support Specialist Provider
- Family Adjustment Counseling Provider

The contractor / sub contactors and /or providers must provide evidence that required standards have been met at the time of renewing their license. This standard can be reviewed by KDADS regional field staff at the time of their reviews and sooner if a potential problem is identified. At any time deemed appropriate by KDADS, a certification may be formally resurveyed by KDADS to determine whether the licensee continues to be in compliance with the requirements, per K.A.R. 30-60-6

## **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.*

**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.

- 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:

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

In addition to broad scale information and outreach by the state and the KanCare MCOs for all Medicaid providers, the providers that support HCBS waiver members have received additional outreach, information, transition planning and education regarding the KanCare program, to ensure an effective and smooth transition. In addition to the broader KanCare provider outreach (including educational tours and weekly stakeholder update calls), the providers that support HCBS waiver members have had focused discussions with state staff and MCO staff about operationalizing the KanCare program; about transition planning (and specific flexibility to support this) for the shift of targeted case management into MCO care management; and about member support in selecting their KanCare plan. The requirements, procedures and timeframes to quality have been clearly communicated via state and MCO information development and outreach as described above, and also via standardized credentialing applications and state-approved contracts which MCOs offered to each existing provider; and related information, including provider manuals has been made available via state and MCO websites.

## Appendix C: Participant Services

### Quality Improvement: Qualified Providers

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

**a. Methods for Discovery: Qualified Providers**

*The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.*

**i. Sub-Assurances:**

- a. Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.**

**Performance Measures**

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

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

**Performance Measure:**

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

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Managed Care Organization (MCO) reports and record reviews**

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b>

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
	Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

**Performance Measure:**

**Number/percent of new licensed/certified waiver provider applicants that initially met licensure requirements, certification requirements, and other waiver standards prior to furnishing waiver services N=Number of new licensed/certified waiver provider applicants that initially met licensure requirements, etc.prior to furnishing waiver services D=Number of all new licensed/certified providers**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**KanCare Managed Care Organization (MCO) reports and record reviews**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95%
<input checked="" type="checkbox"/> <b>Other</b> Specify: KanCare Managed Care Organizations (MCOs)	<input type="checkbox"/> <b>Annually</b>	<input checked="" type="checkbox"/> <b>Stratified</b> Describe Group: Proportionate by MCO
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

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

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

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

**Performance Measure:**

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

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Managed Care Organization (MCO) reports and record reviews**

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

		95%
<input checked="" type="checkbox"/> <b>Other</b> Specify: KanCare Manged Care Organizations (MCOs)	<input type="checkbox"/> <b>Annually</b>	<input checked="" type="checkbox"/> <b>Stratified</b> Describe Group: Proportionate by MCo
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing waiver services**  
 $N = \text{Number of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing wavier services}$   
 $D = \text{Number of all new non-licensed/non-certified providers}$

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Managed Care Organization (MCO) reports and record reviews**

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

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

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

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

**Performance Measure:**

**Number and percent of active providers that meet training requirements**

**N=Number of providers that meet training requirements D=Number of active providers**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Managed Care Organization (MCO) reports and record reviews**

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

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

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

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

i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.  
State staff request, approve, and assure implementation of contractor corrective action planning and/or technical assistance to address non-compliance with performance standards as detected through on-site monitoring, MCO compliance monitoring, survey results and other performance monitoring. These processes are monitored by both contract managers and other relevant state staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy and the operating protocols of the interagency monitoring team.

**ii. Remediation Data Aggregation**

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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify: KanCare Managed Care Organizations (MCOs)	<input type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b>

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

**c. Timelines**

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

- No**  
 **Yes**

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

## Appendix C: Participant Services

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### C-3: Waiver Services Specifications

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

## Appendix C: Participant Services

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### 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.*