

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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

- A.** The State of Kansas requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.
- B. Program Title:**
Kansas - HCBS-I/DD Waiver
- C. Waiver Number:**KS.0224
Original Base Waiver Number: KS.0224.
- D. Amendment Number:**KS.0224.R04.04
- E. Proposed Effective Date:** (mm/dd/yy)
02/01/14
- Approved Effective Date:** 02/01/14
Approved Effective Date of Waiver being Amended: 07/01/09

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

The first purpose of this amendment is to integrate the services provided under this waiver with the State's Section 1115 KanCare Demonstration Project, effective January 1, 2014. KanCare is an integrated delivery system in which nearly all Medicaid services, including services provided under this waiver, will be provided through the KanCare health plans.

The services under this waiver (and some limited related services) had previously been carved out from the KanCare benefit package as implemented January 1, 2013, and continued to be paid on a fee-for-service basis. The State now seeks to provide these waiver services to individuals with intellectual or developmental disabilities (ID/DD) through the KanCare managed care plans. Inclusion in managed care will provide a more robust set of care management resources and more complete integration of all services (long term support services (LTSS) as well as physical and behavioral health). The State proposes that integration of the long term supports and services into KanCare will provide improved care coordination and case management, especially for those with behavioral and physical health related concerns.

Kansas state law provides several protections to ensure a smooth transition for individuals with ID/DD enrolled in KanCare. These provisions are consistent with terms in the KanCare STCs for other LTSS. Under State law adopted in the 2013 legislative session for State fiscal years 2014 and 2015:

- Enrollees may keep current LTSS providers on their approved service plans, even if those providers are not in the network, for 180 days from January 1, 2014, or until a service plan is completed and either agreed upon by the enrollee or resolved through the appeals or a fair hearing process and implemented.
- Enrollees may keep their targeted case managers.

- Enrollees using ID/DD residential providers may access those providers up to one year from 1.1.14, regardless of contracting status.
- The managed care organizations (MCOs) must comply with the specific powers and duties of the CDDOs provided in Kansas law. They also must contract with at least two providers serving each county for each covered LTSS in the benefit package for the enrollees with ID/DD (unless the county has an insufficient number of providers), and must make at least three contract offers to all LTSS providers serving such enrollees at or above the state-set fee for service rate.
- In 2014, the State will conduct an educational tour to provide information to enrollees with ID/DD and LTSS providers. The State will also review, in the first 180 days of 2014, each MCO’s ID/DD service planning process, and will conduct, in 2014 and 2015, training for each MCO to ensure that they understand the DD services system.
- The Kansas Department for Aging and Disabilities Services will, in fiscal years 2014 and 2015, review and approve all plans of care for ID/DD waiver members for which a reduction, suspension or termination of services is proposed.

The State believes that including these services in KanCare will result in better access to services and improved quality of care for KanCare enrollees with ID/DD. Moreover, it will result in stable reimbursement rates for providers and will give the MCOs a compelling financial incentive to keep individuals in a home environment rather than a more costly acute-care facility.

The next purpose of this amendment is to incorporate performance measures in this 1915(c) waiver that are consistent with the STCs, State Quality Measures, and the quality measures included in the KanCare 1115 demonstration-based managed care delivery system. This amendment is submitted pursuant to STC 45 of the KanCare 1115 demonstration program's Centers for Medicare and Medicaid Services (CMS) Special Terms and Conditions. The amendment includes quality assurance performance measures that are evidence-based and outcomes-based to ensure quality of life, effective processes, and the health, safety and welfare of individuals enrolled in the Home and Community Based Services (HCBS). Kansas comprehensively reviewed the HCBS performance measures utilizing technical assistance in collaboration with CMS and Truven Health Analytics to improve performance measures that would be consistent with national standards, State Quality measures, the STCs and the KanCare evaluation design. This waiver will run concurrently with the existing KanCare 1115 demonstration.

Also, included in this amendment where it is applicable, are name changes for the operating agency (Kansas Department of Social & Rehabilitation Services (SRS) to Kansas Department for Aging and Disability Services (KDADS); and name changes for Community Supports and Services (CSS) to Community Services and Programs (CSP) where applicable. Likewise, the Single State Medicaid Agency (SSMA) has been changed from Kansas Health Policy Authority (KHPA) to Kansas Department of Health and Environment (KDHE), Health Care Finance. Finally, Kansas requests to amend the name of the waiver to the Kansas HCBS I/DD waiver and replace all current references of mental retardation and MR/DD to Intellectual Disability and I/DD.

3. Nature of the Amendment

- A. Component(s) of the Approved Waiver Affected by the Amendment.** This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently (*check each that applies*):

Component of the Approved Waiver	Subsection(s)
<input checked="" type="checkbox"/> Waiver Application	Purpose of the Amen
<input checked="" type="checkbox"/> Appendix A – Waiver Administration and Operation	A1, A2-b,A3,A5,A6,
<input checked="" type="checkbox"/> Appendix B – Participant Access and Eligibility	B1.b,B3.f,B5b other,
<input checked="" type="checkbox"/> Appendix C – Participant Services	C.1.c, C.QI.a.ii, b.i, C
<input checked="" type="checkbox"/> Appendix D – Participant Centered Service Planning and Delivery	D.1.a,D.1.b,D.1.c,D.1
<input checked="" type="checkbox"/> Appendix E – Participant Direction of Services	E.1.a,E.1.e, E.1.f, E.1
<input checked="" type="checkbox"/> Appendix F – Participant Rights	F-1,F-2.b,F-3.b,F-3.c
<input checked="" type="checkbox"/> Appendix G – Participant Safeguards	G-1.b. G-1/c.G-1/d.G
<input checked="" type="checkbox"/> Appendix H	H-1 a.i,a.ii, b.i, b.ii
<input checked="" type="checkbox"/> Appendix I – Financial Accountability	I.1, QIS a.i,b.i,ii, I.2.e
<input checked="" type="checkbox"/> Appendix J – Cost-Neutrality Demonstration	J.2.b, J.2.c,i,ii,iii,iv

- B. Nature of the Amendment.** Indicate the nature of the changes to the waiver that are proposed in the amendment (*check each that applies*):

- Modify target group(s)**
- Modify Medicaid eligibility**
- Add/delete services**
- Revise service specifications**
- Revise provider qualifications**
- Increase/decrease number of participants**
- Revise cost neutrality demonstration**
- Add participant-direction of services**
- Other**

Specify:

Integrate the services provided under this waiver with the State's Section 1115 KanCare Demonstration Project, effective January 1, 2014.

Incorporate performance measures in the 1915(c) waiver that are consistent with the STCs, State Quality Measures, and the quality measures included in the KanCare 1115 demonstration-based managed care delivery system.

All Sections have been amended as appropriate to incorporate name changes for the operating agency (Kansas Department of Social & Rehabilitation Services (SRS) to Kansas Department for Aging and Disability Services (KDADS); and name changes for Community Supports and Services (CSS) to Community Services and Programs (CSP) where applicable. Likewise, the Single State Medicaid Agency (SSMA) has been changed from Kansas Health Policy Authority (KHPA) to Kansas Department of Health and Environment (KDHE), Health Care Finance.

Amend the name of the waiver to the Kansas HCBS I/DD waiver and replace all current references of mental retardation and MR/DD to Intellectual Disability and I/DD.

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

1. Request Information (1 of 3)

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

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

- 3 years
- 5 years

Original Base Waiver Number: KS.0224

Waiver Number: KS.0224.R04.04

Draft ID: KS.08.04.06

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

Regular Waiver

- E. Proposed Effective Date of Waiver being Amended:** 07/01/09
- Approved Effective Date of Waiver being Amended:** 07/01/09

1. Request Information (2 of 3)

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

- Hospital**

Select applicable level of care

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

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

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

The State of Kansas currently operates an approved waiver that provides services to eligible children and adults. The purpose for this waiver is to provide the opportunity for innovation in providing Home and Community Based Services (HCBS) to eligible persons who would otherwise require institutionalization in an intermediate care facility for persons with an Intellectual Disability(ICF-I/DD).

Effective 1/1/14, the I/DD waiver services become a part of a comprehensive package of services provided by KanCare health plans (Managed Care Organizations), and are part of a capitated rate.

Consistent with the Developmental Disabilities Reform Act of 1995 (DDRA), the goals and objectives of the waiver continue to center around the policy of the State to provide persons who have intellectual and/or developmental disabilities access to services and supports which allow for these persons opportunities for choices that increase their independence, productivity, integration and inclusion in the community. Further, this range of supports and services will be appropriate to each person and will be provided in a manner that affords the same dignity and respect to persons with intellectual and/or developmental disabilities that would be afforded to any person who does not have a disability. The services available through the waiver can be delivered through multiple service delivery methods. Some services require licensure and that they are managed by the provider, others must be participant-directed, while others may be provided through either a provider managed or participant-directed method. The move to integrate ID/DD waiver services into KanCare does not diminish the waiver's focus on independent living and consumer-driven services. Consumers will continue to have a choice between consumer-directed or agency directed services.

Programmatic oversight and control of the waiver is provided by the Kansas Department for Aging and Disabilities Services, Division of Community Services and Programs(CSP). Consistent with the DDRA, KDADS/CSP contracts with 27 Community Developmental Disability Organizations (CDDOs) across the state to implement requirements related to eligibility, access to services and other duties as defined by the Act.

3. Components of the Waiver Request

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

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

No. This waiver does not provide participant direction opportunities. *Appendix E is not required.*
- F. Participant Rights.** **Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** **Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy.** **Appendix H** contains the Quality Improvement Strategy for this waiver.

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

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

4. Waiver(s) Requested

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

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

Not Applicable

No

Yes

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

No

Yes

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

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

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

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

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

5. Assurances

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

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

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

- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the

needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver:
In 2013, the State of Kansas has made a concentrated effort to address concerns about the inclusion of ID/DD LTSS in KanCare voiced by consumers, their families, providers and advocates. The effort has included the development of a KanCare ID/DD Friends and Family Work Group to assist the State in educating consumers and their families. The Friends and Family Work Group, comprised of consumers and families and friends of consumers, provides guidance and recommendations to KDADS leadership regarding education and policy development for ID/DD LTSS. This group will continue to operate after integration of ID/DD waiver services into KanCare to provide a voice for consumers throughout the implementation process. The Work Group and its education and policy subcommittees provide valuable consumer insight into how best to address concerns or issues that may impact ID/DD consumers.

Family members and guardians with connections to an ID/DD consumer have received an informational letter regarding the inclusion of LTSS in KanCare and how it will function. In addition, KDADS regularly posts ID/DD information on its agency website, including a lengthy fact sheet and FAQs. The KDADS Secretary and staff have spoken at dozens of ID/DD-specific forums and town meetings, as well as broader HCBS forums across the state.

During June, KanCare sessions were held in five cities in different regions of the state. Two sessions were held at each location. Two-hour early afternoon sessions were held with providers in the area, and two-hour sessions for

persons receiving services and their families/guardians were held. In September, another week of trainings were held at four different cities around the State, following the same format as the June trainings. Each MCO answered questions from audience members and visited with participants after the conclusion of the meetings.

The State and members of the Tribal Technical Advisory Group (TTAG) discussed inclusion of ID/DD LTSS in managed care at the July 9 TTAG meeting in Topeka. The State, tribal governments and Indian Health Service, Tribal Organization, and Urban Indian Organization (I/T/U) providers also held two in-person consultation meetings, on July 17 in White Cloud, Kan., and on July 23 in Mayetta, Kan., regarding the inclusion of ID/DD LTSS in managed care as part of the concurrent proposed Section 1115 demonstration amendment.

Tribal notifications were again sent on September 1, 2013, shortly after the State was advised to submit its' amendment for the inclusion of I/DD in KanCare on January 1, 2014.

Follow up information regarding the formal comment period.

Prior to submitting the request to amend this waiver, input was sought from stakeholders. There were discussions held regarding the impact of the changes, as well as alternatives to the proposals presented. Stakeholder input was considered and changes to the original proposals were made as a result of that feedback. Input was sought from tribal governments on November 24, 2010 and again on February 18, 2011.

In the summer of 2011, the State of Kansas facilitated a Medicaid public input and stakeholder consultation process, during which more than 1,700 participants engaged in discussions on how to reform the Kansas Medicaid system. Participants produced more than 2,000 comments and recommendations for reform. After three public forums in Topeka, Wichita and Dodge City, web teleconferences were held with stakeholders representing Medicaid population groups and providers. The State also made an online comment tool available, and a fourth, wrap-up public forum was conducted in Overland Park in August 2011.

The State carefully considered the input from this process and from meetings with advocates and provider associations. In November 2011, Kansas announced a comprehensive Medicaid reform plan that incorporated the themes that had emerged from the public process, including integrated, whole-person care; preserving and creating paths to independence; alternative access models; and enhancing community-based services. The State conducted a formal public comment period related to the KanCare waiver application in June and July 2012. The State also conducted two rounds of tribal consultation, an initial consultation meeting in February 2012, and the second in June and July 2012, incorporating feedback from that process in its August 6th application.

Public input forums and teleconference sessions was held at regional locations offering flexibility and ample opportunity for public input during normal business hours and in the evening hours in an effort to accommodate consumers schedule. Documentation of public input sessions are available upon request by CMS.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

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

Last Name:

Haverkamp

First Name:

Rita

Title:

Agency: Contract Manager

Address: Kansas Department of Health and Environment

Address 2: 900 SW Jackson

City: Topeka

State: Kansas

Zip: 66612-1220

Phone: 66612-1220

Fax: (785) 296-5107 **Ext:** **TTY**

E-mail: (785) 296-4813

rhaverkamp@kdheks.gov

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

Last Name: Wintle

First Name: Greg

Title: HCBS-I/DD Program Manager

Agency: Kansas Department for Aging and Disability Services

Address: 503 Kansas

Address 2:

City: Topeka

State: Kansas

Zip: 66603-3404

Phone: (785) 296-0935 **Ext:** **TTY**

Fax: (785) 296-0557

E-mail:

greg.wintle@kdads.ks.gov

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature: Bobbie Graff-Hendrixson
State Medicaid Director or Designee

Submission Date: Jan 15, 2014

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

Last Name: Mosier

First Name: Susan

Title: Medicaid Director

Agency: KDHE; Division of Health Care Finance

Address: 900 SW Jackson, Room 900N

Address 2:

City: Topeka

State: **Kansas**

Zip: 66612

Phone: (785) 296-3981

Ext: TTY

Fax: (785) 296-4813

E-mail:

Attachment #1: SMosier@kdheks.gov

Transition Plan

Specify the transition plan for the waiver:

The integration of I/DD waiver services into KanCare health plans will take effect January 1, 2014. Persons with I/DD transitioned into KanCare for all but their long-term services and supports on January 1, 2013 and this transition of the waiver services is the final step toward full inclusion for persons with Intellectual/Developmental Disabilities into KanCare. The change is limited to the delivery system. There is no change in eligibility for the waiver services or the scope and amount of services available to waiver participants. Beneficiaries who are American Indians and Alaska Natives will be presumptively enrolled in KanCare, but they will have the option of affirmatively opting-out of managed care. The State's plan for transition of I/DD services to KanCare is multi-pronged:

1. **Beneficiary Education and Notification; Targeted Readiness for HCBS Waiver Providers.** The State has conducted extensive outreach to all I/DD Medicaid beneficiaries and providers regarding the integration of I/DD waivers services into KanCare. There have been multiple rounds of educational tours to multiple cities and towns across the state since July 2012. These tours generally included daily sessions for providers and daily sessions for beneficiaries. During June and September of 2013, there were two tours specifically for I/DD beneficiaries and providers. Another tour is planned for November 2013.

In addition to beneficiary education, 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 frequent stakeholder update calls), the providers that support HCBS waiver members have had focused discussions with state staff and MCO staff about operationalizing and transition planning (and specific flexibility to support this). During the first 180 days of the transition of the HCBS I/DD waiver into KanCare, the State will continue with its educational activities for providers, beneficiaries, and stakeholders .

2. **Efforts to Preserve Provider Relationships.** Members using I/DD waiver services are already part of the KanCare program for non-waiver services, and were allowed to select their existing or any new providers. During this transition members will be allowed to access waiver services with existing providers during the first 180 days after implementation, regardless of whether the provider is in the plans' network. For Residential Services, members will have that additional access safeguard for the first year. For members who do not receive a service assessment and revised service plan within the first 180 days, the health plan will be required to continue the service plan already in existence until a new service plan is created, agreed upon by the enrollee (or after appeal), and implemented.

3. **Information Sharing with KanCare Health Plans.** As part of the transition to KanCare the State and/or the current case management entity will transmit the following data to the consumer's MCO:

- Functional assessments

Current Authorizations

- Plan of Care (along with associated providers)
- Notices of Action
- Historical claims
- Historical Prior Authorizations

This information serves as a baseline for the health plan's care management process and allows the care management team to assess the level of support and education the member may need.

4. **Continuity of Services during the Transition.** In order to maintain continuity of services and allow health plans time to outreach and assess the members, the State of Kansas has required the KanCare health plans to authorize and continue all existing I/DD services for a period of 180 days.

Also, to ensure continuity of services, the State will allow providers to continue to use the State's MMIS to enter claims. The option will ease a technical consideration of the transition for providers who do not have experience billing directly to commercial clearinghouses or other payers.

5. **Intensive State Oversight.** Kansas Department for Aging and Disability Services long term care licensure and quality assurance staff will provide oversight and "ride alongs" with health plan staff to ensure a smooth transition for the first 180 days.

The State will require each health plan to maintain a call center and will review call center statistics daily. The State will also hold regular calls with each health plan to discuss key operational activities and address any concerns or questions that arise. Issues to be discussed can include, but are not limited to, network reporting and provider panel size reports, call center operations, reasons for member calls, complaint and appeal tracking, health plan outreach activities, service planning, data transfer, claims processing, and any other issue encountered during transition. The State will also review beneficiary complaints and grievances/appeals during the initial implementation on a frequent basis, and will have comprehensive managed care oversight, quality improvement and contract management. Also, the State will review any reductions or terminations of services and must approve any reduction in advance of the change up through June 30, 2015. Enrollees will have all appeal rights afforded through the MCO and State fair hearings process, including the ability to continue services during the appeal.

6. **Designation of an Ombudsman.** There is a KanCare Ombudsman in the Kansas Department for Aging and Disability Services. The KanCare Ombudsman helps people in Kansas who are enrolled in a KanCare plan, with a primary focus on individuals participating in the HCBS waiver program or receiving other long term care services through KanCare. The KanCare Ombudsman helps health plan members with access and service concerns, provides information about the KanCare grievance and appeal process that is available through the KanCare plans and the state fair hearing process, and

assists KanCare consumers seek resolution to complaints or concerns regarding their fair treatment and interaction with their KanCare plan.

The KanCare Ombudsman will:

Help consumers to resolve service-related problems when resolution is not available directly through a provider or health plan.

Help consumers understand and resolve notices of action or non-coverage.

Assist consumers learn and navigate the grievance and appeal process at the KanCare plan, and the State fair hearing process, and help them as needed.

Assist consumers to seek remedies when they feel their rights have been violated.

Assist consumers understand their KanCare plan and how to interact with the programs benefits

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

The waiver is operated by the State Medicaid agency.

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

The Medical Assistance Unit.

Specify the unit name:

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

The 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:

The 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 consumers 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.

The 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, as the HCBS waiver programs merge into comprehensive managed care, KDHE will have oversight of all portions of the program and the KanCare

MCO contracts, and will collaborate with KDADS regarding HCBS program management, including those items identified in part (a) above. The key component of that collaboration will be through the KanCare Interagency Monitoring Team, an important part of the overall state's KanCare Quality Improvement Strategy, which will provide quality review and monitoring of all aspects of the KanCare program – engaging program management, contract management, and financial management staff from both KDHE and KDADS.

The services in this waiver are becoming 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) will be guided by the KanCare Quality Improvement Strategy. A critical component of that strategy is the engagement of the KanCare 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 IMT meetings – will be on a quarterly basis. While continuous monitoring will be conducted, including on monthly and other intervals, the aggregation, analysis and trending processes will be built around that quarterly structure. Kansas will be amending the KanCare QIS to include the concurrent HCBS waiver connections, and once the QIS is operational (and within 12 months of KanCare launching) will be seeking CMS approval of amendments of the HCBS waivers that embed the KanCare QIS structure.

Appendix A: Waiver Administration and Operation

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

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

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

Community Developmental Disability Organizations (CDDOs):

CDDOs could be considered both Contracted Entities as well as local/regional non-state entities.

Consistent with the Developmental Disabilities Reform Act of 1995 (DDRA), the Kansas Department for Aging and Disability Services contracts with 27 CDDOs across the State to perform the following functions;

- a. Directly or by subcontract, serve as a single point of application of referral for services, and assist all persons with a developmental disability to have access to and an opportunity to participate in community services and;
- b. Provide either directly or by subcontract, services to persons with a developmental disability, including, but not limited to, eligibility determination and explanation of available services and service providers.

With regard to delegated functions, CDDOs are responsible for the following;

Participant waiver enrollment: CDDOs are responsible for performing waiver intake activities including taking applications for waiver services, and when necessary, referring individuals for determination of Medicaid and/or disability eligibility determination.

Waiver enrollment managed against approved limits: CDDOs are responsible for applying the state's policies concerning the selection of individuals to enter the waiver and for assisting with the maintenance of a waiting list for entrance to the waiver.

Level of care evaluation: CDDO activities include compiling and submitting to the State, the information that is necessary to evaluate potential entrants to the waiver and the continuing need for the level of care that the waiver provides for participants.

Review of participant service plans: CDDOs in collaboration with the KanCare MCOs are responsible for review and submission of service plans.

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

Appendix A: Waiver Administration and Operation

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

- Not applicable**
- Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

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

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

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

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

Appendix A: Waiver Administration and Operation

- 5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
State of Kansas - Department for Aging and Disability Services - Community Services and Programs Commission.

Appendix A: Waiver Administration and Operation

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

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

The KanCare Quality Improvement Strategy and interagency agreements/monitoring teams will 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 will be ongoing assessment of the results of onsite monitoring and in-person reviews with a sample of HCBS waiver participants. The KanCare Interagency Monitoring Team (IMT) will meet quarterly, and during the initial year of the KanCare program will have additional meetings of members involved in HCBS quality activities at both the single state Medicaid agency (KDHE) and the operating agency (KDADS). During the first 12 months of KanCare, as noted in the 1115 STC #45, the state will have flexibility in merging existing quality monitoring practices and protocols into the Comprehensive State Quality Strategy addressed in STC #37, and reporting the results of the strategy in connection of the HCBS waiver service oversight and monitoring. Once that review and merger process is completed, and related HCBS waiver amendments are submitted (by 12.13.13), the comprehensive KanCare SQS will be revised within 90 days of approval of the HCBS waiver amendments submitted. Included in the revised SQS will be a description of monitoring/assessment of the contracted entities, including the IMT's quarterly review of the results that monitoring/assessment.

Contracted and/or local/regional non-state entities are monitored through a CDDO review process. This process was developed to ensure that the contracting partners with KDADS/CSP, the Waiver Operating Agency, were operating within the established parameters. The parameters include: CMS rules/guidelines, Kansas statute and regulations, CDDO contracts with KDADS/CSP, local and regional policies. The review is conducted on-site. The primary objective is to insure that the CDDO effectively assures participant access, person-centered service/support design and delivery, choice of services and service providers, assurance of adequate safeguards, and an appropriate methodology to assure that services for which the person is eligible are provided and that the services provided are paid for. The review provides for;

1. On-going day to day oversight of how the CDDO implements their policies regarding eligibility, assessment, choice, access, and quality assurance and is completed by KDADS Regional CSP Quality Enhancement field staff.
2. Each CDDO is reviewed every three years, with special reviews conducted for demonstrated cause, by trained teams of reviewers (this includes staff from other CDDOs, staff from local community service providers, advocates and consumers) and administered by KDADS/CSP Quality Management Staff.
3. KDADS/CSP is empowered to utilize staged remedies/enforcement actions depending on severity of compliance issues, including CAPs, fines and contract penalties. A key component to the CDDO review process is the involvement of persons served, families/guardians, CDDO peers, affiliated service providers and other interested stakeholders.

On a quarterly basis, performance results obtained by KDADS through the Quality Management process, which includes information related to the performance of contractors, is presented to KDHE for feedback and recommendations. The information will be included as part of the comprehensive KanCare QIS, and relevant results and any adjustments will be addressed with the KanCare MCOs. If recommendations for changes are made as a result of the quality reviews, KDADS will review those outcomes with KDHE.

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 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 <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <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 checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other

		Specify: _____
	<input type="checkbox"/> Other Specify: _____	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<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="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: _____

Performance Measure:

Number and percent of waiver amendments and renewals reviewed and approved by the State Medicaid Agency prior to submission to CMS by the State Medicaid Agency
N=Number of waiver amendments and renewals 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 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 checked="" 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="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<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 checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Presentation of Waiver Policy Changes

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <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="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<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 checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

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

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

Data Source (Select one):

Meeting minutes

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" 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="checkbox"/> Other Specify: _____	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: _____
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: _____
	<input type="checkbox"/> Other Specify: _____	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<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 checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
	<input type="checkbox"/> Other Specify: _____

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

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 consumers, advocacy organizations, provider groups and other interested stakeholders to monitor the state quality strategy and performance standards and discuss priorities for remediation and improvement. The state quality improvement strategy includes protocols to review cross-service system data to identify trends and opportunities for improvement related to all Kansas waivers, policy and procedure development and systems change initiatives.

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

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 type="checkbox"/> Other Specify: _____	<input type="checkbox"/> Annually

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

c. Timelines

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

No

Yes

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input type="radio"/> 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="radio"/> 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="radio"/> Intellectual Disability or Developmental Disability, or Both					
	<input checked="" type="checkbox"/>	Autism	5		<input checked="" type="checkbox"/>
	<input checked="" type="checkbox"/>	Developmental Disability	5		<input checked="" type="checkbox"/>
	<input checked="" type="checkbox"/>	Intellectual Disability	5		<input checked="" type="checkbox"/>
<input type="radio"/> Mental Illness					
	<input type="checkbox"/>	Mental Illness			

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	<input type="checkbox"/>	Serious Emotional Disturbance			

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

All persons must achieve a converted score of 35 or greater on the Developmental Disability Profile. In addition, children between the ages of five and ten must achieve a score of at least 21 on the Children's Assessment. Individuals whose sole diagnosis is Severe Persistent Mental Illness are not eligible for HCBS-I/DD services.

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

- Not applicable. There is no maximum age limit**
- The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Specify the percentage: _____

- Other**

Specify:

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

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

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

The following dollar amount:

Specify dollar amount:

The dollar amount (select one)

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

Specify the formula:

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

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

Specify percent: |

Other:

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

Other safeguard(s)

Specify:



Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	8352
Year 2	8652
Year 3	8952
Year 4	9252
Year 5	9100

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

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

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

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

Purpose(s) the State reserves capacity for:

Purposes	
Money Follows the Person (MFP)	

Appendix B: Participant Access and Eligibility

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

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

Money Follows the Person (MFP)

Purpose (*describe*):

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

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

Describe how the amount of reserved capacity was determined:

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

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

Waiver Year	Capacity Reserved
Year 1	30
Year 2	30
Year 3	30
Year 4 (renewal only)	30
Year 5 (renewal only)	30

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:

The KDADS Policy regarding Service Access states that the KDADS contract with Community Developmental Disability Organizations will outline HCBS access to services. The contract states that access will be first-come first-served, based on the requested date for services to begin unless the person meets the definition of crisis and is granted immediate access. The following is the definition of crisis;

Persons who are in crisis or imminent risk of crisis and whose needs can only be met through services available through the HCBS/I/DD waiver are those persons who:

- a. Require protection from confirmed abuse, neglect, or exploitation or written documentation of pending action for same; or
- b. Are at significant, imminent risk of serious harm to self or others in their current situation.

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:

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

- A special income level equal to:

Select one:

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

Specify percentage: _____

- A dollar amount which is lower than 300%.

Specify dollar amount: _____

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

Select one:

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

The State uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

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

- The following standard included under the State plan**

Select one:

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

(select one):

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

Specify the percentage:

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

Specify dollar amount:

- A percentage of the Federal poverty level**

Specify percentage:

- Other standard included under the State Plan**

Specify:

- The following dollar amount**

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

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

Specify:

- Other**

Specify:

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

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

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

- Not Applicable**
 The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:

Specify:

Specify the amount of the allowance (*select one*):

- SSI standard
- Optional State supplement standard
- Medically needy income standard
- The following dollar amount:

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

- The amount is determined using the following formula:

Specify:

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

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

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

- The amount is determined using the following formula:

Specify:

- Other

Specify:

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

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

Select one:

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

Specify:



Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

i. Allowance for the personal needs of the waiver participant

(select one):

- SSI standard
- Optional State supplement standard
- Medically needy income standard
- The special income level for institutionalized persons
- A percentage of the Federal poverty level

Specify percentage: |

- The following dollar amount:

Specify dollar amount: | 727 If this amount changes, this item will be revised

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

Specify formula:

- Other

Specify:

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

Select one:

- Allowance is the same
 Allowance is different.

Explanation of difference:

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

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

Select one:

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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

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

Specify the entity:

Per the Developmental Disability Reform Act, KDADS contracts with 27 Community Developmental Disability Organizations to perform level of care evaluations and reevaluations.

- 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:

Individuals performing initial evaluations must have a minimum of six months experience in the field of developmental disabilities services and a bachelor's degree or additional experience in the field which may be substituted for at the rate of six months of experience for each semester. KDADS may grant exceptions to the minimal requirements on an individualized basis. It is anticipated that the only exceptions that would be granted would be for persons who do not yet have the six months of experience in the field of developmental disabilities. If this exception is granted it would only be done with the understanding that this person would be working under the direct supervision of a qualified person for the period of time until the new person had six months of experience. KDADS will maintain a log to track granted exceptions. KDADS/CSP meets with individuals performing evaluations on a quarterly basis to discuss the assessment process and any particular questions the assessors may have regarding how to answer particular questions on the assessments.

- 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.

To be eligible for HCBS-I/DD services and consistent with ICF-I/DD level of care criteria, persons must first meet the definition of a person who is intellectually or developmentally disabled. Consistent with K.S.A. 39-1803 (f) and (h), persons who are residents of Kansas and who are intellectually or developmentally disabled are those whose condition presents and extreme variation in capabilities from the general population which manifests itself in the developmental years resulting in a need for life-long interdisciplinary services. A copy of the complete eligibility policy is available to CMS upon request.

In addition, to be ICF-I/DD or HCBS-I/DD eligible, a person must achieve a minimum converted score of 35 on the Developmental Disability Profile, a valid and standardized instrument used for waiver eligibility determination by the State of Kansas since initial waiver approval. Children between the ages of five and ten must also achieve a minimum score of 21 on the Children's Assessment to be HCBS-MR/DD eligible.

In the event that the CDDO uses a sub-contractor to perform level of care evaluations, the same qualifications that are identified in Appendix B-6.c apply to persons employed by the sub-contractor to perform the level of care evaluations. The CDDO will require the sub-contractor to provide documentation that all of its' employees doing level of care evaluations meet the minimum qualifications.

- e. Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):
- The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
 - A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

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

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

Initial evaluations and annual re-evaluations are conducted by persons meeting the minimum qualifications outlined in Appendix B-6c.. Person's are evaluated upon initial application for services and then again during the persons

next immediate birth month, and then annually, during the persons' birth month.

In general, individuals performing evaluations are employees of the CDDO's and are typically classified as "Waiver Screeners". In some situations, the CDDO may sub-contract out the screening but under no circumstance can the sub-contractor also provide any direct service to the waiver participant.

The assessment, The Developmental Disabilities Profile, assesses the person in three domains; medical, mal-adaptive and adaptive. A variety of questions are answered in each domain and then the answers are formulated into a converted score.

Results of the Level of Care Evaluation/Reevaluations will be shared with the MCOs.

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

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

Specify the other schedule:

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

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

Specify the qualifications:

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

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

- 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:

Electronic documentation is kept by the Department for Aging and Disability Services and written and/or electronically retrievable documents are also kept by the targeted case managers and by the persons for agencies designated as responsible for the performance of evaluations and reevaluations.

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**

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<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: _____

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

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 checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review

<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input checked="" type="checkbox"/> Other Specify: Contracted Assessors	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Proportionate by MCO
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: _____
	<input type="checkbox"/> Other Specify: _____	

Data Aggregation and Analysis:

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

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<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 type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: _____

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Assessor and Assessment Records

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<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 checked="" type="checkbox"/> Other Specify: Contracted assessors	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: _____
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other

		Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

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

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:

Record reviews

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

		Confidence Interval = 95%
<input checked="" type="checkbox"/> Other Specify: Contracted assessors	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Proportionate by MCO
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<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 type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

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

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

Current language still in because CDDO continues to do the Assessment

Participants will receive an initial assessment, a reassessment and an annual recertification for continued level of care eligibility determination using a standardized BASIS (Basic Assessment and Services Information System) assessment instrument. Reassessment for waiver services is recertified annually. Provider enrollment contracts between the operating agency, Kansas KDADS, and CDDOs (Community Developmental Disability Organization) contract to:

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

The Quality Survey Process includes assurance of:

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

The above performance standards have been developed in partnership with consumers, advocates, provider organizations and state operating and authority agencies to monitor waiver assurances and minimum standards. The performance standards are monitored through the current Quality Survey Process which is based on a uniform, standard assessment instrument and is implemented and utilized statewide. The Quality Survey process is conducted by state regional field staff through annual on-site, in-person reviews of 2.5% of waiver participants to review for and address any identified occurrences of non-compliance with regulatory and performance standards.

Providers are informed of all quality and performance improvement indicators and performance standards. Based on any noted deficiencies identified through the Quality Survey Process, state staff (Regional Field Staff) request Corrective Action Plans from providers for remediation. State staff provides technical assistance, as appropriate.

Statewide / Regional / Provider data is compiled, trended, reviewed, and disseminated to providers through the Performance Improvement Analysis Process. Each provider receives annual data trending which identifies Provider specific performance levels related to statewide performance standards and statewide averages. Corrective Action Plan requests and/or technical assistance to remediate negative trending are included in annual provider reports where negative trending is evidenced.

ii. Remediation Data Aggregation

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

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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

c. Timelines

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

- No**
- Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

Consumers are provided information regarding their choices on at least an annual basis. The consumer and his/her case manager receive form MR-5a which indicates initial or continued eligibility for HCBS services. Consumers complete the form MR-1 to indicate their choice of either Home and Community-Based services or services provided by an ICF-I/DD prior to their enrollment in either of these services. These forms are available to CMS upon request through the Medicaid agency or the operating agency.

CDDOs and TCMs are responsible for informing individuals or their legal representatives about feasible alternatives of freedom of choice between waiver and institutional services. On a continuous basis, the MCOs will foster the freedom of choice between waiver and institutional services.

- 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.

Copies are kept by the Community Developmental Disability Organization and also by the targeted case managers and by the persons or agencies designated as responsible for the performance of evaluations and reevaluations.

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 consumers, states are required to capture language preference information. This information is captured in the demographic section of the instrument.

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

Each contracted provider is required by Kansas regulation to make every reasonable effort to overcome any barrier that consumers may have to receiving services, including any language or other communication barrier. This is achieved by having staff available to communicate with the 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 consumer 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.

In addition, I/DD waiver members, as KanCare members, have access to comprehensive interpreter services via their chosen managed care organization.

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	Day Supports		
Statutory Service	Overnight Respite Care		
Statutory Service	Personal Assistant Services		
Statutory Service	Residential Supports		
Statutory Service	Supported Employment		
Supports for Participant Direction	Financial Management Services (FMS)		
Other Service	Assistive Services		
Other Service	Medical Alert Rental		
Other Service	Sleep Cycle Support		
Other Service	Specialized Medical Care		
Other Service	Supportive Home Care		
Other Service	Wellness Monitoring		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

Day Supports

Service Definition (*Scope*):

Day Supports are regularly occurring activities that provide a sense of participation, accomplishment, personal reward, personal contribution, or remuneration and thereby serve to maintain or increase adaptive capabilities, productivity, independence or integration and participation in the community. Day Supports also includes the provision of pre-vocational services which are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. These services include teaching such concepts as compliance, attendance, task completion, problem solving and safety.

Such activities shall be appropriate for or lead to a lifestyle as specified in the persons' Person Centered Support Plan. These opportunities can include socialization, recreation, community inclusion, adult education, and skill development in the areas of employment, transportation, daily living, self-sufficiency, and resource identification and acquisition.

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

A. HCBS I/DD Day Supports can NOT be provided to anyone who is an inpatient of a hospital, a nursing facility, or an ICF-I/DD

B. Persons eligible for services through the local education authority shall not have access for reimbursement unless they are at least 18 years of age, are graduating from high school before the age of 22 and a transition plan is developed by a transition team that includes the CDDO representative or the CDDOs designee.

C. To Receive Reimbursement (5 of 7 days a week): It is the desired outcome of KDADS, that participants receiving Day Supports have the opportunity to receive such services consistent with their preferred lifestyle a minimum of 25 hours per week. KDADS understands that each individual is unique and that this outcome can be met in a variety of ways.

Individuals must be out of their home a minimum of 5 hours per day, or a total of 25 hours per week unless;

- a. a person operates a home based business, or;
- b. a person is unable to be out of their home due to a medical necessity or significant physical limitations related to frailty and for which a physician has provided current (within the past 6 months and reviewed at least every 6 months thereafter) written verification for the necessity to remain in the home.

D. Pre-vocational services cannot duplicate services funded under the Rehabilitation Act of 1973 or under the provisions of IDEA.

Those persons eligible to receive services while they remain in the home must participate in activities consistent with their person-centered support plan and to the extent possible, replicate activities in which the person would be participating if they were out of the home.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Service Providers

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Supports

Provider Category:

Agency

Provider Type:

Community Service Providers

Provider Qualifications

License (specify):

Licensed by KDADS/CSP consistent with Regulations 30-63-01 through 30-63-32.

Certificate (specify):

Other Standard (specify):

Consistent with the Developmental Disabilities Reform Act, Providers;

- * Must submit policies and procedures for KDADS approval.
- * All staff must be in compliance with the KDADS Background check policy.
- * All staff must be trained in medication administration and Abuse, Neglect and Exploitation.

Providers must also be a Medicaid or KMAP enrolled provider; and must either contract with a KanCare MCO or be an approved out-of-network provider with a KanCare MCO.

Verification of Provider Qualifications

Entity Responsible for Verification:

Kansas Department for Aging and Disability Services, the Kansas Department of Health and Environment and the KanCare MCOs.

Frequency of Verification:

At least annually.

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):

Overnight Respite Care

Service Definition (Scope):

Overnight Respite Care is designed to provide relief for the individual's family member who serves as an unpaid primary care giver. Respite is necessary for families who provide constant care for individuals so family members are able to receive periods of relief for vacations, holidays and scheduled periods of time off. Overnight Respite care is provided in planned segments and includes payment during the individual's sleep time.

Overnight Respite Care may be provided in the following location(s) and will allow for staff to sleep:

- *Individual's family home or place of residence;
- *Licensed Foster Home;
- *Facility approved by KDHE or KDADS which is not a private residence, or;
- *Licensed Respite Care Facility/Home.

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

Overnight Respite care may not be provided by a consumer's spouse OR by a parent of a consumer who is a minor child under eighteen years of age.

Individuals who receive Overnight Respite Care services may not also receive Residential Supports or Personal

Assistant Services as an alternative to Overnight Respite.

Overnight Respite Care services cannot be provided to an individual who is an inpatient of a hospital, a nursing facility, or an ICF-I/DD when the inpatient facility is billing Medicaid, Medicare and/or private insurance.

Room and board is not part of the cost of service unless provided as part of respite care in a facility approved by the state that is not a private residence.

A maximum of 60 nights of overnight respite per calendar year is allowed.

The KanCare MCOs will not allow payment for claims for both Overnight Respite Care and Sleep Cycle Support on the same dates of service.

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person**
- Relative**
- Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Service Provider
Individual	Overnight Respite Care Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Overnight Respite Care

Provider Category:

Agency

Provider Type:

Community Service Provider

Provider Qualifications

License (specify):

Licensed by KDADS/CSP (K.S.A. 39-1801, et seq.) or by the Kansas Department of Health and Environment if the care is provided in a licensed foster care setting. K.S.A. 65-508.

Certificate (specify):

Other Standard (specify):

Providers must also be a Medicaid or KMAP enrolled provider; and must either contract with a KanCare MCO or be an approved out-of-network provider with a KanCare MCO.

Verification of Provider Qualifications

Entity Responsible for Verification:

KDADS, the Kansas Department of Health and Environment and the KanCare MCOs.

Frequency of Verification:

On-going but at least annually.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Overnight Respite Care

Provider Category:

Individual

Provider Type:

Overnight Respite Care Provider

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Providers must be at least 16 years of age, 18 if a sibling of the participant and an enrolled Medicaid Provider. A parent may not provide support to his/her minor child. Providers are required to pass background checks consistent with the KDADS Background Check Policy and comply with all regulations related to Abuse, Neglect and Exploitation.

Consistent with K.A.R. 30-63-10, the participant is responsible for documenting that the individual provider has received sufficient training to provide the needed service.

Providers must also be a Medicaid or KMAP enrolled provider; and must either contract with a KanCare MCO or be an approved out-of-network provider with a KanCare MCO.

Verification of Provider Qualifications

Entity Responsible for Verification:

KDADS, the Kansas Department of Health and Environment and the KanCare MCOs.

Frequency of Verification:

On-going but at least annually.

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:

Personal Care

Alternate Service Title (if any):

Personal Assistant Services

Service Definition (*Scope*):

Personal Assistant Services are available to individuals who choose to self-direct all or a portion of their services and live in one of the following types of settings.

A setting that would otherwise be considered an adult residential setting requiring services to be provided by an entity licensed by KDADS-CSP.

A setting where the person lives with someone meeting the definition of family.

Note: Family is defined as any person immediately related to the beneficiary. Immediate-related family members are parents (including adoptive parents), grandparents, a spouse, aunts, uncles, sisters, brothers, first cousins and any step-family relationships.

A setting where a child, five to 21 years of age, who is in the custody of the Kansas Department of Children and Families(DCF) but not living with someone meeting the definition of family.

A setting in which a child, 15 years of age or older, who resides in a setting with persons who do not meet the definition of family and have not been appointed the legal guardian or custodian.

Personal Assistant Services means one or more personal assistants on an individualized (one-to-one basis) assuring the health and welfare of the individual and supporting the individual with the tasks that the person would typically do for themselves or by themselves if they did not have a disability. Such services include assisting individuals in performing a variety of tasks promoting independence, productivity, and integration. Personal Assistant Services include assisting with activities of daily living - ADLs (bathing, grooming, toileting, transferring, health maintenance activities including but not limited to extension of therapies, feeding, mobility and exercises), independent activities of daily living - IADLs (shopping, housecleaning (related to the recipient), seasonal chores, meal preparation, laundry, financial management) and support services - SS (socialization and recreation activities), assistance in obtaining necessary medical services assistance in reporting changes in the individual's condition and needs, and accompanying or providing transportation to accomplish any of the tasks listed above.

This service provides necessary assistance for individuals both in their home and community.

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

- a) All Personal Assistant Services will be arranged for, and purchased under the individual's or responsible party's written authority, and paid through an enrolled Financial Management Services provider consistent with and not exceeding the individual's Plan of Care. Individuals will be permitted to choose qualified provider(s) who have passed background checks that assure compliance with KAR 30-63-28(f).
- b) Individual's who may at some point determine that they no longer want to self-direct their Personal Assistant Services will have the opportunity to receive their previously approved waiver services, without penalty.
- c) A Personal Assistant may not perform any duties for the individual that would otherwise be consistent with the Supported Employment definition, Sections 1.a & b.
- d) Personal Assistant Services cannot be provided by the Legal Guardian for the recipient.
- e) It is the expectation that waiver recipients who need assistance with independent activities of daily living (IADL) tasks, should rely on these informal/natural supporters for this assistance unless there are extenuating circumstances that have been documented in the Person-Centered Support Plan (for example, the PCSP defines the role of the Personal Assistant as a person who is teaching the recipient how to perform the skill). In accordance with this expectation, Personal Assistant Services should not be used for lawn care, snow removal, shopping, ordinary housekeeping (as this is a task that can be completed in conjunction with the housekeeping/laundry done by the individual with whom the recipient lives), and meal preparation during the times when the person with whom the recipient lives would normally prepare a meal for themselves/themselves.
- f) Personal Assistant retainer services may be provided up to maximum of 14 days per calendar year, at a level consistent with the approved Plan of Care. These services are provided during time when the individual is an inpatient f a hospital, a nursing facility, or an ICF/I-DD when the facility is billing Medicaid, Medicare and/or private insurance and are provided to assist individuals who self-direct their care with retaining their current care provider(s).
- g) Individuals in Residential Supports can NOT also receive Personal Assistant Services for the same residential supports, or any of the array of Family/Individual Supports. This does not prevent the conversion of Day Supports to Personal Assistant Services.
- h) Individuals receiving Day Supports can NOT also receive Personal Assistant Services for the same Day supports. This does not prevent the conversion of Residential Supports to Personal Assistant Services.

A person may have several personal assistants providing him or her care on a variety of days at a variety of times, but a person may not have more than one assistant providing care at any given time. The State will not make payments for multiple claims filed for the same time on the same dates of service.

In addition, Plans of Care for which it is determined that the provisions of Personal Assistant Services would be a duplication of services will not be approved.

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	Individual Personal Assistants

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Assistant Services

Provider Category:

Individual

Provider Type:

Individual Personal Assistants

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Providers must be at least 16 years of age, 18 if a sibling of the participant and must receive payment through a Medicaid Enrolled Provider. A parent may not provide support to his/her minor child.

Providers are required to pass background checks consistent with the KDADS Background Check Policy and comply with all regulations related to Abuse, Neglect and Exploitation.

Consistent with K.A.R. 30-63-10, the participant is responsible for documenting that the individual provider has received sufficient training to provide the needed service.

Verification of Provider Qualifications

Entity Responsible for Verification:

KDADS, the Kansas Department of Health and Environment and the KanCare MCOs.

Frequency of Verification:

On-going but at least annually.

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:

Residential Habilitation

Alternate Service Title (if any):

Residential Supports

Service Definition (Scope):

These supports are provided to waiver individuals who live in a residential setting and do not live with their birth or adoptive parents. This service provides assistance, acquisition, retention and/or improvement in skills related to activities of daily living such as, but not necessarily limited to, personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Payments for Residential Supports are not made for room and board, the cost of facility maintenance, upkeep, and improvement, other than such costs for modifications or adaptations to the facility required to assure the health and safety of individuals or to meet the requirements of the applicable life safety code. Payment for Residential Supports does not include payments made directly to members of the individuals' immediate family. Payments will not be made for routine care and supervision which would be expected to be provided by immediate family members or for which payment is made by a source other than Medicaid.

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

All providers of Residential Supports shall be in compliance with K.A.R. 30-63-21 through 30-63-30.

Residential Supports for adults are provided for individuals 18 years of age or older and must occur in a setting, without regard to siblings, where the person does not live with someone who meets the definition of family, and are provided by entities licensed by KDADS-CSP.

Children's Residential Supports provide direct assistance to persons in order to meet their daily living situation and serve to maintain or increase adaptive, capabilities, independence, integration and participation in the community. Children's Residential Services are for children not in the custody of DCF and are between the ages of 5 and 22. These services are provided outside the family home in a home which;

1. Is licensed by KDHE as a family foster home, meets all State or KDADS requirements, or is another residential setting that is approved by KDADS.
2. Serves no more than two (2) children unrelated to the family foster care provider, and;
3. Is located in or near the child's home community and school so the child remains in contact with the natural family, if appropriate, and maintains established community connections such as but not limited to; the child's school and teachers, friends and neighbors, community activities, church and health care professionals.

Plans of Care for which it is determined that the provision of both Residential Supports and Day Supports would constitute a duplication of services will not be approved.

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Service Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Supports

Provider Category:

Agency

Provider Type:

Community Service Provider

Provider Qualifications

License (*specify*):

Licensed by KDADS-CSP consistently with Regulations 30-63-01 through 30-63-32, or the Kansas Department of Health and Environment.

Certificate (*specify*):

Other Standard (*specify*):

Medicaid enrolled providers.

Consistent with the Developmental Disabilities Reform Act, Providers;

- * Must submit policies and procedures for KDADS-CSP approval.
- * All staff must be in compliance with the KDADS Background check policy.
- * All staff must be trained in medication administration and Abuse, Neglect and Exploitation.

Providers must also be a Medicaid or KMAP enrolled provider; and must either contract with a KanCare MCO or be an approved out-of-network provider with a KanCare MCO.

Verification of Provider Qualifications

Entity Responsible for Verification:

KDADS, the Kansas Department of Health and Environment and the KanCare MCOs.

Frequency of Verification:

On-going, but at least annually.

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:

Supported Employment

Alternate Service Title (if any):

Supported Employment

Service Definition (*Scope*):

Supported Employment is competitive work in an integrated setting with on-going support services for individuals who have I/DD. Competitive work is work for which an individual is compensated in accordance with the Fair Labor Standards Act. An integrated work setting is a job site that is similar to that of the general work force. Such work is supported by any activity needed to sustain paid employment by persons with disabilities.

Supported Employment services are ongoing supports to participants who, because of their disabilities, need intensive ongoing support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated setting in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.

The following supported employment activities are designed to assist individuals in acquiring and maintaining employment:

1. Individualized assessment.
2. Individualized job development and placement services that create an appropriate job match for the individual and the employer.
3. On the job training in work and work related skills required to perform the necessary functions of the job.
4. Ongoing monitoring of the individuals' performance on the job.
5. Ongoing support services necessary to assure job retention as identified in the person-centered support plan.
6. Training in related skills essential to secure and retain employment.

Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C., 1401 et seq.) and FFP is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: 1) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program, 2) Payments that are passed through to users of supported employment programs; or 3) Payments for training that is not directly related to an individual's supported employment program.

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

- a. Supported employment must be provided in a place of business or a setting that has otherwise been approved by KDADS-CSP.
- b. Supported employment activities must not be provided until the individual has applied to the local Rehabilitation Services office. The HCBS/I-DD Waiver will fund Supported Employment activities until the point in time when Rehabilitation Services funding for Supported Employment begins. The HCBS-I/DD waiver funded Supported Employment activities must not be provided simultaneously with activities directly reimbursed by Kansas Vocational Rehabilitation Services. If a member wants to pursue competitive employment in an integrated setting, the member must apply for Vocational Rehabilitation services. Members get assistance from their TCM to access this support option. Once that service option is made available to the member, supported employment services cannot be accessed through this waiver, to ensure no duplication of services.
- c. Supported Employment cannot be provided in a sheltered work setting.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Service Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

Community Service Provider

Provider Qualifications

License (*specify*):

Licensed by KDADS-CSP consistently with Regulations 30-63-01 through 30-63-32.

Certificate (*specify*):

Other Standard (*specify*):

Medicaid Enrolled Provider.

Consistent with the Developmental Disabilities Reform Act, Providers;

- * Must submit policies and procedures for KDADS-CSP approval.
- * All staff must be in compliance with the KDADS Background check policy.
- * All staff must be trained in medication administration and Abuse, Neglect and Exploitation.

Providers must also be a Medicaid or KMAP enrolled provider; and must either contract with a KanCare MCO or be an approved out-of-network provider with a KanCare MCO.

Verification of Provider Qualifications

Entity Responsible for Verification:

KDADS/CSP, the Kansas Department of Health and Environment and the KanCare MCOs.

Frequency of Verification:

At least annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Financial Management Services

Alternate Service Title (if any):

Financial Management Services (FMS)

Service Definition (*Scope*):

Financial management services (FMS) are provided for individuals that are aging or disabled and have chosen to self-direct some or all of their services. FMS will be provided within the scope of the Agency with Choice (AWC) model. The AWC FMS is the employer option model that Kansas is making available to individuals who reside in their own private residences or the private home of a family member and have chosen to self-direct their services.

Within this model the individual or responsible party enters into a joint-employment arrangement with the AWC FMS and must work collaboratively with the AWC FMS to ensure the receipt of quality, needed support services from direct support workers. The AWC FMS provider is responsible for certain employer functions, including:

FMS assists the individual or individual's representative by providing two distinct types of tasks: (1)

Administrative Tasks and (2) Information and Assistance (I & A) Tasks.

FMS Administrative Tasks include, but are not limited to, the following:

- a) Verification and processing of time worked and the provision of quality assurance;
- b) Preparation and disbursement of qualified direct support worker payroll in compliance with federal, state and local tax; labor; and workers' compensation insurance requirements; making tax payments to appropriate tax authorities;
- c) Performance of fiscal accounting and expenditure reporting to the individual or individual's representative

and the state, as required.

FMS Information and Assistance Tasks include, but are not limited to, the following:

- a) Explanation of all aspects of self-direction and subjects pertinent to the individual or individual's representative in managing and directing services;
- b) Assistance to the individual or individual's representative in arranging for, directing and managing services;
- c) Assistance in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services;
- d) The offer of practical skills training to enable participants or representatives to independently direct and manage waiver services such as recruiting and hiring direct service workers, managing workers, and providing effective communication and problem-solving.

The extent of the assistance furnished to the individual or individual's representative is specified in the service plan. This service does not duplicate other waiver services including case management. Where the possibility of duplicate provision of services exists, the individual's service plan shall clearly delineate responsibilities for the performance of activities.

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

Access to this service is limited to individuals or individual's representatives who direct some or all of their services or to individuals or individual's representatives who are planning to direct some or all of their services. Financial Management Service (FMS) is reimbursed per member per month. FMS service may be accessed by the participant at a minimum monthly or as needed in order to meet the needs of the participant. A participant may have only one FMS provider per month.

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Enrolled Medicaid Provider

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction

Service Name: Financial Management Services (FMS)

Provider Category:

Agency

Provider Type:

Enrolled Medicaid Provider

Provider Qualifications

License (specify):

N/A

Certificate (specify):

N/A

Other Standard (specify):

1. Each potential Agency With Choice Financial Management Service (AWC FMS) entity must complete and maintain in good standing:

a. KDADS Provider Agreement

i. Applications are available on the following website:

<http://www.srs.ks.gov/agency/css/Pages/default.aspx> or www.aging.state.ks.us.

ii. The application must be completed and returned electronically as identified on the website.

iii. Application must be complete. Incomplete applications or the failure to provide required

documentation will result in the application being pended awaiting completed documentation.

iv. KDADS Provider Agreements are valid for three (3) years; unless revoked; withdrawn or surrendered.

b. Medicaid Provider Agreement

i. Medicaid Provider Agreement cannot be obtained without the presentation of a valid, approved KDADS provider agreement.

ii. Medicaid provider requirements can be located at: <https://www.kmap-state-ks.us>.

c. A corporation or other entity that is required to be registered with the Secretary of State's office.

i. Be in good standing with all Kansas laws/business requirements.

ii. Owners/Principles/Administrators/Operators have no convictions of embezzlement, felony theft, or fraud.

iii. Businesses established to provide FMS to individuals that live in a separate household from the owner, primary operator or administrator of the FMS business.

iv. Business is established to provide FMS to more than one individual.

d. Insurance defined as:

i. Liability insurance

1) Annual liability with a \$500,000 minimum

ii. Workers Compensation Insurance

1) Policy that covers all workers

2) Meets all requirements of the State of Kansas

3) Demonstrates the associated premiums are paid in a manner that ensures continuous coverage

4) Unemployment insurance (if applicable)

5) Other insurances (if applicable)

e. Annual Independent Financial Audit:

i. Shall be arranged for and submitted by all AWC FMS providers.

f. Demonstrate financial solvency

i. Evidence that 30 days operation costs are met (estimate of cash requirements will be estimated utilizing the past quarter's performance from the date of review; or if a new entity, provider must estimate the number of individuals that they reasonably expect to serve utilizing nominal costs).

1) Cash (last three bank statements)

2) Open line of credit (statement(s) from bank/lending institution)

3) Other (explain)

g. Maintain required policies/procedures including but not limited to;

i. Policies/procedures for verification of Medicaid billing in accordance with approved rates, and for services as authorized by POC.

ii. Policies/procedures for billing AWC FMS administrative fees

iii. Policies/procedures to receive and disburse Medicaid funds, track disbursements and provide reports as requested

1) Report to self-direct individuals semi-annually billing/dispensed on their behalf

2) Report to the State of Kansas as requested

iv. Policies/procedures that ensure proper/appropriate background checks are conducted on all individuals (FMS provider and DSW) in accordance with program requirements

v. Policies/procedures that ensure that self-directing individuals follow the pay rate procedures as established by the State of Kansas when setting direct support workers pay rates.

1) Clear identification of how this will occur

2) Prohibition of wage/benefit setting by AWC FMS provider

3) Prohibition of "recruitment" of self-direct individuals (HCBS waiver consumers/customers and/or DSW staff) by enticements/promises of greater wages and/or benefits through the improper use of Medicaid funds.

vi. Policies/procedures that ensure proper/appropriate processing of time worked, disbursement of pay checks, filing of taxes and other associated responsibilities

vii. Policies/procedures regarding the provision of Information & Assistance services

viii. Policies/procedures for Grievance. The grievance policy is designed to assure a method that Direct Support Workers can utilize to address hours paid that differ from hours worked, lack of timely pay checks, bounced pay checks, and other AWC FMS issues.

Providers must also be a Medicaid or KMAP enrolled provider; and must either contract with a KanCare MCO or be an approved out-of-network provider with a KanCare MCO.

Verification of Provider Qualifications

Entity Responsible for Verification:

KDADS, the Kansas Department of Health and Environment and the KanCare MCOs.

Frequency of Verification:

At a minimum, every three years or more frequently as deemed necessary by KDADS, KDHE or the KanCare MCOs.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Assistive Services

Service Definition (Scope):

Assistive Services are supports or items that meet an individual's assessed need by providing and/or promoting the person's health, independence, productivity, or integration in to the community and are directly related to the individual's Person Centered Support Plan (PCSP) with measureable outcomes. Examples include, but are not limited to wheelchair modifications, ramps, lifts, modifications to bathrooms and kitchens (specifically related to accessibility), and assistive technology (i.e. items that improve communication, mobility or assist with activities of daily living (ADLs) or instrumental activities of daily living (IADLs) in the home and work place).

The assistive service(s) purchased must 1) increase the consumer's ability to live independently, or 2) increase or enhance the consumer's productivity, or 3) improve the consumer's health and welfare.

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

- a) All Assistive services will be purchased under the consumer's or guardian's written authority, and paid to either the CDDO or a qualified entity as determined by the CDDO and will not exceed the prior authorized purchase amount.
- b) No home modification will increase the finished square footage of an existing structure.
- c) Purchase or rent of new or used assistive technology is limited to those items not covered through regular Medicaid.
- d) Assistive Services will not be accessed for new construction.
- e) Home modifications will be utilized on property where the recipient leases or owns, in the family home if still living there, but not on agency owned and operated property unless and informed exception is made by KDADS-CSP.
- f) No outside party can be required to subsidize and Assistive Service request. The contractor must agree to accept full payment from Medicaid.

Costs associated with needed structural modifications to property owned or operated by providers are considered the responsibility of the provider. The State may grant an exception, but will require the agency to pay for the costs associated with the removal, transfer and re-installation of modifications to the consumer's new home. Consumer specific items such as portable lifts and wheelchair modifications would be covered regardless of where the consumer lives.

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Service Provider
Agency	Durable Medical Equipment Provider
Agency	Community Developmental Disability Organization

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Assistive Services

Provider Category:

Agency

Provider Type:

Community Service Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Providers must also be a Medicaid or KMAP enrolled provider; and must either contract with a KanCare MCO or be an approved out-of-network provider with a KanCare MCO.

All general contractor service providers, if required must meet the local city and state building codes. DME service providers must distribute product and services in accordance with K.A.R 30-5-58.

All non-licensed general contractor must present a current certification of worker's compensation and general liability insurance, including proof of business establishment at a minimum of 2 consecutive years.

Any property approved for a home modification must be occupied and owned by the participants or the parent or legally responsible individual where the participant resides. A home modification cannot increase the finished square footage of a home.

Durable medical equipment (DME) providers must meet statutory requirement (K.S.A. 65-1626) to provide DME services and be registered with the Kansas Board of Pharmacy.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

KDADS, the Kansas Department of Health and Environment, the local Community Developmental Disability Organization (CDDO) and the KanCare MCOs.

Frequency of Verification:

At least annually.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Services

Provider Category:

Agency

Provider Type:

Durable Medical Equipment Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Providers must also be a Medicaid or KMAP enrolled provider; and must either contract with a KanCare MCO or be an approved out-of-network provider with a KanCare MCO.

All general contractor service providers, if required must meet the local city and state building codes. DME service providers must distribute product and services in accordance with K.A.R 30-5-58.

All non-licensed general contractor must present a current certification of worker's compensation and general liability insurance, including proof of business establishment at a minimum of 2 consecutive years.

Any property approved for a home modification must be occupied and owned by the participants or the parent or legally responsible individual where the participant resides. A home modification cannot increase the finished square footage of a home.

Durable medical equipment (DME) providers must meet statutory requirement (K.S.A. 65-1626) to provide DME services and be registered with the Kansas Board of Pharmacy.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

KDADS, the Kansas Department of Health and Environment, the local Community Developmental Disability Organization (CDDO) and the KanCare MCOs.

Frequency of Verification:

At least annually.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Services

Provider Category:

Agency

Provider Type:

Community Developmental Disability Organization

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

Providers must also be a Medicaid or KMAP enrolled provider; and must either contract with a KanCare MCO or be an approved out-of-network provider with a KanCare MCO.

All general contractor service providers, if required must meet the local city and state building codes. DME service providers must distribute product and services in accordance with K.A.R 30-5-58.

All non-licensed general contractor must present a current certification of worker's compensation and general liability insurance, including proof of business establishment at a minimum of 2 consecutive years.

Any property approved for a home modification must be occupied and owned by the participants or the parent or legally responsible individual where the participant resides. A home modification cannot increase the finished square footage of a home.

Durable medical equipment (DME) providers must meet statutory requirement (K.S.A. 65-1626) to provide DME services and be registered with the Kansas Board of Pharmacy.

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

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

KDADS and the KanCare MCOs.

Frequency of Verification:

At least annually

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:

Medical Alert Rental

Service Definition (Scope):

The purpose of this service is to provide support to a consumer who has a medical need that could become critical at anytime. The medical alert device is a small instrument carried or worn by the consumer which, by

the push of a button, automatically dials the telephone of a predetermined responder who will answer the call for help 24 hours a day, 7 days a week.

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

Rental, not the purchase, of this equipment is covered. Maintenance of equipment is included as a part of the rental agreement.

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	Individual Provider
Agency	Hospital
Agency	Community Service Provider
Agency	Emergency Transportation Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Medical Alert Rental

Provider Category:

Individual

Provider Type:

Individual Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Providers must be at least 16 years of age, 18 if a sibling of the participant and an enrolled Medicaid Provider. A parent may not provide support to his/her minor child.

Providers are required to pass background checks consistent with the SRS Background Check Policy and comply with all regulations related to Abuse, Neglect and Exploitation.

Consistent with K.A.R. 30-63-10, the participant is responsible for documenting that the individual provider has received sufficient training to provide the needed service.

Providers must also be a Medicaid or KMAP enrolled provider; and must either contract with a KanCare MCO or be an approved out-of-network provider with a KanCare MCO.

Verification of Provider Qualifications

Entity Responsible for Verification:

KDADS-CSP, the Kansas Department of Health and Environment and the KanCare MCOs.

Frequency of Verification:

On-going but at least annually.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Medical Alert Rental

Provider Category:

Agency

Provider Type:

Hospital

Provider Qualifications

License (specify):

K.S.A. 65-410 et. seq.

Certificate (specify):

N/A

Other Standard (specify):

Providers must also be a Medicaid or KMAP enrolled provider; and must either contract with a KanCare MCO or be an approved out-of-network provider with a KanCare MCO.

Services and equipment must conform to industry standards and any federal, state, and local laws and regulations that govern this service.

The emergency response center must be staffed on a 24 hour/7 days a week basis by trained personnel.

Verification of Provider Qualifications

Entity Responsible for Verification:

KDADS-CSP, The Kansas Department of Health and Environment and the KanCare MCOs.

Frequency of Verification:

On-going but at least annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Medical Alert Rental

Provider Category:

Agency

Provider Type:

Community Service Provider

Provider Qualifications

License (specify):

Licensed Community Service Provider consistent with K.A.R. 30-63-01, etc.

Certificate (specify):

N/A

Other Standard (specify):

Providers must also be a Medicaid or KMAP enrolled provider; and must either contract with a KanCare MCO or be an approved out-of-network provider with a KanCare MCO.

Services and equipment must conform to industry standards and any federal, state, and local laws and regulations that govern this service.

The emergency response center must be staffed on a 24 hour/7 days a week basis by trained personnel.

Verification of Provider Qualifications

Entity Responsible for Verification:

KDADS-CSP, The Kansas Department of Health and Environment and the KanCare MCOs.

Frequency of Verification:
On-going but at least annually.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Medical Alert Rental

Provider Category:

Agency

Provider Type:

Emergency Transportation Provider

Provider Qualifications

License (specify):

K.S.A. 65-6102 et. seq.

Certificate (specify):

N/A

Other Standard (specify):

Providers must also be a Medicaid or KMAP enrolled provider; and must either contract with a KanCare MCO or be an approved out-of-network provider with a KanCare MCO.

Services and equipment must conform to industry standards and any federal, state, and local laws and regulations that govern this service.

The emergency response center must be staffed on a 24 hour/7 days a week basis by trained personnel.

Verification of Provider Qualifications

Entity Responsible for Verification:

KDADS-CSP, The Kansas Department of Health and Environment and the KanCare MCOs.

Frequency of Verification:

On-going but at least annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Sleep Cycle Support

Service Definition (Scope):

The primary purpose of Sleep Cycle Support is to give overnight assistance to recipients living with a person who meets the definition of family, in case of emergencies or to assist with repositioning. The attendant also provides turning and repositioning as well as assistance with taking or reminding the recipient to take medications that are normally self-administered. The attendant does not perform any other personal care, training, or homemaker tasks. Individuals/entities who may or may not be licensed by KDADS for other purposes will provide this service.

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

A Sleep Cycle Support attendant is ready to call a doctor, hospital, or provide other assistance if an emergency occurs. The attendant must be immediately available, but can sleep when not needed.

The period of service for Sleep Cycle Support is a minimum of 8 hours and cannot exceed 12 hours.

There are several mechanisms in place to prevent duplicate billing between Sleep Cycle Support and Personal Assistant Services.

- 1) To receive Sleep Cycle Support, the person must have a documented need for medical supports at night. In the absence of this documentation the State would not approve a plan with Sleep Cycle Support as a service.
- 2) The needs of all persons receiving Personal Assistant Services are assessed on an individual basis and, if Sleep Cycle Support is needed, then the need for PA services would be limited to those times not covered by the Sleep Cycle Supports.
- 3) Documentation requirements for these services include start and end times. As a part of our provider review process, timesheets would be reviewed to assure there is not overlap with any of these services and if overlap is found, there would be a recoupment of funds.

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	Individual Sleep Cycle Support Providers
Agency	Community Service Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Sleep Cycle Support

Provider Category:

Individual

Provider Type:

Individual Sleep Cycle Support Providers

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Providers must be at least 16 years of age, 18 if a sibling of the participant and an enrolled Medicaid Provider. A parent may not provide support to his/her minor child. Providers are required to pass background checks consistent with the KDADS Background Check Policy and comply with all regulations related to Abuse, Neglect and Exploitation.

Consistent with K.A.R., 30-63-10, the participant is responsible for documenting that the individual

provider has received sufficient training to provide the needed service.

Providers must also be a Medicaid or KMAP enrolled provider; and must either contract with a KanCare MCO or be an approved out-of-network provider with a KanCare MCO.

Verification of Provider Qualifications

Entity Responsible for Verification:

KDADS-CSP, the Kansas Department of Health and Environment and the KanCare MCOs.

Frequency of Verification:

ON-going but at least annually.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Sleep Cycle Support

Provider Category:

Agency

Provider Type:

Community Service Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Providers must be at least 16 years of age, 18 if a sibling of the participant and an enrolled Medicaid Provider. A parent may not provide support to his/her minor child. Providers are required to pass background checks consistent with the KDADS Background Check Policy and comply with all regulations related to Abuse, Neglect and Exploitation.

Consistent with K.A.R., 30-63-10, the participant is responsible for documenting that the individual provider has received sufficient training to provide the needed service.

Providers must also be a Medicaid or KMAP enrolled provider; and must either contract with a KanCare MCO or be an approved out-of-network provider with a KanCare MCO.

Verification of Provider Qualifications

Entity Responsible for Verification:

KDADS-CSP, the Kansas Department of Health and Environment and the KanCare MCOs.

Frequency of Verification:

On-going but at least annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialized Medical Care

Service Definition (*Scope*):

This service provides long-term nursing support for medically-fragile and technology-dependent beneficiaries. The required level of care must provide medical support for beneficiaries needing ongoing, daily care that would otherwise require the beneficiary to be in a hospital. The intensive medical needs of the beneficiary must be met to ensure that the person can live outside of a hospital or intermediate care facility for persons with an intellectual disability.

For the purpose of this waiver, a provider of Specialized Medical Care must be an RN or an LPN under the supervision of an RN. Providers of this service must be trained with the medical skills necessary to care for and meet the medical needs of beneficiaries within the scope of the State’s Nurse Practice Act.

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

It is the responsibility of the provider agency to ensure that qualified nurses are employed and able to meet the specific medical needs of the beneficiaries.

Specialized medical care does not duplicate any other Medicaid state plan service or other services available to the beneficiary at no cost.

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

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

Access to Specialized Medical Care Services is limited to those recipients who's needs can only be met by an RN or LPN as determined by KDADS-CSP based on how often and to what extent a person needs can only be met through the use of medical technology.

Specialized Medical Care Services recipients may not also receive Residential Supports or Personal Assistant Services as an alternative to Specialized Medical Care Services.

Specialized Medical Care services are limited to a maximum of an average of twelve hours per day or 1448 units per month. One unit is equal to 15 minutes.

Services furnished to a beneficiary who is an inpatient or resident of a hospital, nursing facility, ICF/I/D, or IMD are not reimbursable.

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	Individual Specialized Medical Care Provider
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Care

Provider Category:

Individual

Provider Type:

Individual Specialized Medical Care Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

The individual is determined by KDADS-CSP to be qualified to provide the service. Providers are trained with the medical skills necessary to care for and meet the medical needs of beneficiaries within the scope of the State's Nurse Practice Act.

Providers must also be a Medicaid or KMAP enrolled provider; and must either contract with a KanCare MCO or be an approved out-of-network provider with a KanCare MCO.

Verification of Provider Qualifications

Entity Responsible for Verification:

KDADS-CSP, the Kansas Department of Health and Environment and the KanCare MCOs.

Frequency of Verification:

At least annually

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Specialized Medical Care

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License (specify):

Licensed by the State of Kansas as a Home Health Agency as specified in K.S.A. 65-5101 through K.S.A. 65-5117.

Certificate (specify):

Other Standard (specify):

Providers must also be a Medicaid or KMAP enrolled provider; and must either contract with a KanCare MCO or be an approved out-of-network provider with a KanCare MCO.

Verification of Provider Qualifications

Entity Responsible for Verification:

Kansas Department of Health and Environment and the KanCare MCOs.

Frequency of Verification:

At least annually.

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:

Supportive Home Care

Service Definition (Scope):

Supportive Home Care services are provided by an agency (not self-directed by the person receiving services) to assist a person living with;

Someone meeting the definition of family. OR;

A setting where a child, five to 21 years of age, who is in the custody of the Kansas Department Aging and Disability Services but not living with someone meeting the definition of family. OR;

A setting in which a child, 15 years of age or older, who resides in a setting with persons who do not meet the definition of family and have not been appointed the legal guardian or custodian.

Note: Family is defined as any person immediately related to the beneficiary. Immediate-related family members are parents (including adoptive parents), grandparents, a spouse, aunts, uncles, sisters, brothers, first cousins and any step-family relationships.

These are individualized (one-to-one) services that provide direct assistance to waiver recipients in daily living and personal adjustment, attendant care, assistance with medications that are ordinarily self-administered and accessing medical care, supervision, reporting changes in the recipient's conditions and needs, extension of therapy services, ambulation and exercise, household services essential to health care at home or performed in conjunction with assistance in daily living (e.g. shopping, meal preparation, clean-up after meals, bathing, using appliances, dressing, feeding, bed-making, laundry and cleaning the bathroom and kitchen) and household maintenance related to the recipient. The Supportive Home Care worker can accompany or transport the recipient to accomplish any of the tasks listed above to provide essential supervision or support for community activities.

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

a) Supportive home care may not be provided by a recipient's spouse or by a parent of a recipient who is a minor child under eighteen years of age.

b) Supportive home care recipients may not also receive Residential Supports or Personal Assistant Services.

c) Supportive Home Care (SHC) services may not be provided in a school setting and may not be used for education or as a substitute for educationally related services or for transition services as outlined in the individual's Individual Education Plan. In order to verify that SHC services are not used as a substitute, an SHC services Schedule (MR-10) should clearly define the division of educational services and SHC services. Educational services should be equal to or greater than seven hours per day in which school is regularly in session. These hours do not have to be consecutive hours. The minimal numbers of hours required for kindergarten students is seven hours per day for those who are eligible for full-day kindergarten services and three and-a-half hours per day for those students who are eligible for half-day kindergarten.

d) Supportive home care services are limited to a maximum of an average eight hours per day in any given month, and to only the activities described above unless sufficient rationale is provided for hours in excess of an average of eight hours per day. The absolute maximum allowable supportive home care is an average of twelve hours per day in any given month.

e) Supportive home care hours are provided ONLY when the primary care givers are present OR regularly scheduled to be absent; otherwise, respite hours should be utilized.

f) A recipient can receive supportive home care services from more than one worker, but no more than one worker can be paid for services at any given time of the day.

g) Supportive home care services can not be provided to a recipient who is an inpatient of a hospital, a nursing facility, or an ICF/ID when the inpatient facility is billing Medicaid, Medicare and/or private insurance.

It is the expectation that waiver recipients who need assistance with independent activities of daily living (IADL) tasks and who live with someone meeting the definition of family who is capable of performing the IADL tasks, should rely on these informal/natural supporters for this assistance unless there are extenuating or

specific circumstances that have been documented in the Person-Centered Support Plan (for example, the PCSP defines the role of the SHC provider as a person who is teaching the recipient how to perform the skill). In accordance with this expectation, supportive home care should not be used for;

- * Lawn care;
- * Snow removal;
- * Shopping;
- * Ordinary housekeeping (as this is a task that can be completed in conjunction with the housekeeping/laundry done by the individual with whom the recipient lives);
- * Meal preparation during the times when the person with whom the recipient lives would normally prepare a meal for themselves.

Supportive Home Care retainer services may be billed up to a maximum of 14 days per calendar year, at a level consistent with the approved Plan of Care. These services are provided during time when the individual is an inpatient of a hospital, a nursing facility, or an ICF/ID when the facility is billing Medicaid, Medicare and/or private insurance and are provided to assist individuals who self-direct their care with retaining their current care provider(s).

Supportive Home Care providers may be reimbursed for up to 20 hours per calendar year to allow for payment to Supportive Home Care attendants to attend training opportunities that will benefit the attendant in the provision of services to the participant.

A description of expectations for supportive home care workers must be maintained and available for review. The descriptions are subject to audit.

If services are being provided to children accessing services from the Local Education Authority, a separate description of expectations for supportive home care workers (one for when in school and one for when not in school) may be appropriate and must also be available for review. The services provided in this waiver will in no way supplant those available through a child's IEP or IFSP or services available through Section 504 of the Rehabilitative Services Act of 1973. The descriptions are also subject to audit.

As a part of the Plan of Care development process, the needs of all persons receiving Supportive Home Care Services are assessed on an individual basis and, if Day Supports are also needed, then the need for Supportive Home Care services are limited to those times not covered by the Day Supports.

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Service Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supportive Home Care

Provider Category:

Agency

Provider Type:

Community Service Provider

Provider Qualifications

License (*specify*):

N/A

Certificate (*specify*):

N/A

Other Standard (*specify*):

Medicaid Enrolled Provider. The Medicaid Enrolled Provider must affiliate with the Community Developmental Disability Organization(s) in the areas for which it chooses to provide services.

Supportive Home Care providers must be at least 16 years of age, 18 if a sibling of the participant. A parent may not provide support to his/her minor child.

Supportive Home Care providers are required to pass background checks consistent with the KDADS Background Check Policy and comply with all regulations related to Abuse, Neglect and Exploitation.

Providers must also be a Medicaid or KMAP enrolled provider; and must either contract with a KanCare MCO or be an approved out-of-network provider with a KanCare MCO.

Verification of Provider Qualifications

Entity Responsible for Verification:

KDADS-CSP, The Kansas Department of Health and Environment and the KanCare MCOs.

Frequency of Verification:

At least annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Wellness Monitoring

Service Definition (*Scope*):

Wellness Monitoring is a process whereby a registered nurse evaluates the level of wellness of a consumer to determine if the consumer is properly using medical health services as recommended by a physician and if the health of the consumer is sufficient to maintain him/her in his/her place of residence without more frequent skilled nursing intervention.

Wellness Monitoring includes checking and/or monitoring the following;

1. Orientation to surroundings
2. Skin Characteristics
3. Edema
4. Personal Hygiene
5. Blood Pressure
6. Respiration
7. Pulse
8. Adjustments to medication

For members who access this service, the results will be included in information shared between the member's TCM and MCO care management staff.

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

Participants must have medical conditions that require monitoring if they are not receiving skilled nursing care. Only one visit by a Registered Nurse, per 60 days, is covered.

A consumer eligible for wellness monitoring lives in a non-institutional setting and, through the utilization of wellness monitoring is visited no more often than every 60 days, is able to maintain his/her independence at home, or in an alternative living arrangement. This service is provided by Registered Nurses only, who may be employed by home health agencies licensed by the Department of Health and Environment, KDADS licensed agencies, public health departments or Community Service Providers. Direct medical intervention is obtained through the appropriate medical provider and is not funded by this program.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency
Agency	Community Service Provider
Agency	Public Health Department

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Wellness Monitoring

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License (*specify*):

Licensed by the Kansas Department of Health and Environment consistent with K.S.A. 65-5101 through K.S.A.65-5117.

Certificate (*specify*):

Other Standard (*specify*):

Registered Nurse as specified in K.S.A. 65-5101 through K.S.A. 65-5117.

Providers must also be a Medicaid or KMAP enrolled provider; and must either contract with a KanCare MCO or be an approved out-of-network provider with a KanCare MCO.

Verification of Provider Qualifications

Entity Responsible for Verification:

Kansas Department of Health and Environment and the KanCare MCOs.

Frequency of Verification:

At least annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Wellness Monitoring

Provider Category:

Agency

Provider Type:

Community Service Provider

Provider Qualifications

License (*specify*):

Licensed by KDADS-CSP consistent with K.A.R.30-63-1 through K.A.R. 30-63-32 and the Kansas Department of Health and Environment through K.S.A. 65-5101 through K.S.A.-5117

Certificate (*specify*):

Other Standard (*specify*):

Registered Nurse as specified in K.S.A. 65-5101 through K.S.A. 65-5117.

Providers must also be a Medicaid or KMAP enrolled provider; and must either contract with a KanCare MCO or be an approved out-of-network provider with a KanCare MCO.

Verification of Provider Qualifications

Entity Responsible for Verification:

KDADS-CSP, the Kansas Department of Health and Environment and the KanCare MCOs.

Frequency of Verification:

At least annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Wellness Monitoring

Provider Category:

Agency

Provider Type:

Public Health Department

Provider Qualifications

License (*specify*):

Licensed by the Kansas Department of Health and Environment consistent with K.S.A. 65-5101 through K.S.A.65-5117,

Certificate (*specify*):

Other Standard (*specify*):

Registered Nurse as specified in K.S.A. 65-5101 through K.S.A. 65-5117.

Providers must also be a Medicaid or KMAP enrolled provider; and must either contract with a KanCare MCO or be an approved out-of-network provider with a KanCare MCO.

Verification of Provider Qualifications

Entity Responsible for Verification:

Kansas Department of Health and Environment and the KanCare MCOs.

Frequency of Verification:

At least annually

Appendix C: Participant Services

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

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

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

Check each that applies:

- As a waiver service defined in Appendix C-3. Do not complete item C-1-c.**
- As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option). Complete item C-1-c.**
- As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). Complete item C-1-c.**
- As an administrative activity. Complete item C-1-c.**

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

Case management services for persons served on the HCBS I/DD Waiver are provided by individuals employed by entities annually licensed by the Kansas Department for Aging and Disabilities Services and contracting with KanCare MCOs. These entities are also enrolled Medicaid providers for Developmental Disabilities Targeted Case Management services. Each individual case manager is required to have met the following education and training requirements:

- Six months full time experience in a field of human services; and
- A bachelor degree or additional full-time experience in the field of developmental disabilities services, which may be substituted for the degree at the rate of 6 months of full-time experience for each missing semester of college; and
- Successful completion of the designated case management training and assessment by scoring eighty five percent or higher on each module.

The KanCare MCOs will work with the member, the member's TCM and the other participants in the member's support planning team, to assist in the development of a comprehensive plan of care that address the service and support needs across the member's life and to assist the member in identifying and accessing services and supports beyond the I/DD waiver services. This will be a part of the KanCare MCOs' administrative functions around care management and member support within the KanCare program. The work of the KanCare MCO staff will supplement the effort of the member's I/DD waiver and TCM providers.

Appendix C: Participant Services

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

- a. Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (*select one*):

- No. Criminal history and/or background investigations are not required.**
- Yes. Criminal history and/or background investigations are required.**

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

Community Developmental Disability Organizations (CDDOs), Community Service Providers (CSP's), and all other affiliates (excluding environmental/adaptive equipment vendors), providing I/DD funded services shall conduct appropriate background checks to ensure that no employee has a history of abuse, neglect and/or exploitation of children or vulnerable adults. Background checks are required of employees regardless of whether they are providing a licensed or non-licensed service.

CDDOs and Community Service Providers have the discretion to determine which criminal background check (s) it will use. Checks are usually done through many of the available online providers or through the Kansas Bureau of Investigation.

CDDOs and CSPs and other affiliates are responsible for ensuring background checks are completed on their employees and employees of persons or families for whom they perform administrative duties. CDDOs, CSPs and other affiliates may require additional or follow-up background checks as they deem appropriate. Results of background checks must be available for review by authorized KDADS, CDDO, KDHE and KanCare MCO staff.

KDADS regional field staff review staff files as a part of their on-going provider review process. As a part of the file review, regional staff confirm that documentation is present that the person has passed the criminal background investigation.

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):

At initial employment CDDOs, CSPs and other affiliates shall perform the following background checks:

- a. DCF-Adult Protective Services Registry
- b. DCF-Child Protective Services Registry
- c. Kansas Department of Health and Environment-Kansas Nurse Aid Registry

The State of Kansas Department for Children and Families is responsible for maintaining the Adult and Child Protective Services Registries and the Kansas Department of Health and Environment is responsible for maintaining the Kansas Nurse Aid Registry.

CDDOs and CSPs, and other affiliates are responsible for ensuring background checks are completed on their employees and employees of persons or families for whom they perform administrative duties. CDDOs, CSPs and other affiliates may require additional or follow-up background checks as they deem appropriate. Results of background checks must be available for review by authorized KDADS, CDDO, KDHE and KanCare MCO staff.

KDADS regional Quality Enhancement staff review staff files as a part of their on-going provider review process. As a part of the file review, Quality Management staff confirm that documentation is present that the person has passed the required abuse registry screenings

Appendix C: Participant Services

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

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

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

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

Facility Type	
Licensed Foster Care Setting	
Adult Group Home	

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

HCBS Residential Supports can be provided to individuals residing in a setting of four or more people, but not greater than eight. To assure a home and community-based character in these settings, supports for each person are based on the individual's person-centered support plan. A provider is required, to the best of its ability and within available funding, to honor the lifestyle choices of each person receiving services. In addition, these services are provided by licensed providers and the services are monitored by KDADS/CSP to assure that opportunities for increased independence, productivity, integration, and community inclusion are prevalent. In addition, recipients have full access to typical facilities in a home such as a kitchen with cooking facilities, small dining areas, and the setting provide for privacy and easy access to resources and activities in the community.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Licensed Foster Care Setting

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Personal Assistant Services	<input type="checkbox"/>
Supportive Home Care	<input type="checkbox"/>
Day Supports	<input type="checkbox"/>
Overnight Respite Care	<input type="checkbox"/>
Sleep Cycle Support	<input type="checkbox"/>
Specialized Medical Care	<input type="checkbox"/>
Residential Supports	<input checked="" type="checkbox"/>
Supported Employment	<input type="checkbox"/>
Medical Alert Rental	<input type="checkbox"/>
Wellness Monitoring	<input type="checkbox"/>
Financial Management Services (FMS)	<input type="checkbox"/>
Assistive Services	<input type="checkbox"/>

Facility Capacity Limit:

No more than 2 non-related children in a setting unless an exception is granted by KDADS

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

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>

Standard	Topic Addressed
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

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

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Adult Group Home

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Personal Assistant Services	<input type="checkbox"/>
Supportive Home Care	<input type="checkbox"/>
Day Supports	<input type="checkbox"/>
Overnight Respite Care	<input type="checkbox"/>
Sleep Cycle Support	<input type="checkbox"/>
Specialized Medical Care	<input type="checkbox"/>
Residential Supports	<input checked="" type="checkbox"/>
Supported Employment	<input type="checkbox"/>
Medical Alert Rental	<input type="checkbox"/>
Wellness Monitoring	<input type="checkbox"/>
Financial Management Services (FMS)	<input type="checkbox"/>
Assistive Services	<input type="checkbox"/>

Facility Capacity Limit:

8

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

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>

Standard	Topic Addressed
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

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

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.*

Legally responsible persons are able to provide supportive home care services and sleep cycle support services as long as they are identified in the participant's person-centered plan as someone the consumer is choosing to provide his/ her paid services. The amount of services provided by individuals chosen by the participant is determined by a needs assessment completed by the participant's team which, at a minimum, includes, the participant, case manager and a legally responsible person (if one has been appointed). . K.A.R. 30-63-10 states that providers must be at least 16 years of age, 18 if the sibling of the participant and that the parent of a minor child cannot be paid to provide that child services. As a part of the needs assessment, the responsibilities of the legally responsible person (if one has been appointed) are defined. Payment to the legally responsible person cannot be made for performance of any responsibility identified as a typical responsibility for the legally responsible person. Only those activities performed by a responsible person which go beyond the activities the responsible person would ordinarily perform and are necessary to assure the health and welfare of the

participant and to avoid institutionalization will be reimbursed.

Under the proposed Personal Assistant Services, a legally responsible person cannot be paid to provide support to the person for whom the person is legally responsible. Under the other self-directed services, a legally responsible person can be paid provided he/she meets all other identified requirements. Kansas has no policy that limits the amount of identified needed supports that can be provided by the person. Kansas has no policies that allow for —extra-ordinary care|| to be provided by the parent of a participant under the age of 18.

Consistent with K.A.R. 30-63-10, legally responsible persons must also have received the training necessary to perform the activities necessary to meet the persons' needs. Both the Plan of Care and the claims are compared electronically through MMIS. The Plan of Care includes services to be furnished, their frequency, the type and ID number of the provider who will provide each service, and the costs of each service

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.

Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

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

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

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

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

A relative/legal guardian may provide, whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-3, supportive home care, personal assistant services (if the consumer lives with the relative/guardian) and sleep cycle support services. Kansas has no policy that limits the amount of the identified needed support provided by a specific person. The person-centered planning process is the key to determine if the legal guardian will be a paid provider of supports. The plan should indicate the specific types of services that will be provided by the legal guardian and how it was determined that it was in the best interest of the participant that the specific services would be provided by the legal guardian.

Limitations on the amount of services are governed by the assessed need of the consumer and monitored by the consumer's KanCare MCO. In addition, assurance that services provided by a relative/legal guardians are in the best interests of the consumer are monitored in periodic review by KDADS Field staff as well as ongoing monitoring by the consumer's chosen KanCare MCO. Assurance that payments are made only for services rendered provided through the KanCare MCOs' corporate compliance/program integrity activities, as well as monitoring and review of fraud, abuse and waste activities/outcomes via the state's Quality Improvement Strategy.

- Other policy.**

Specify:

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

Any qualified provider may enroll with the State's fiscal agent as a Medicaid provider. There is a specific department called Provider Enrollment, and an 800 telephone number is available. The State assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing

services provided under the waiver. The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care. When potential providers contact Provider Enrollment, they can request an enrollment packet that includes information such as the provider requirements for each service. This information is also available online.

The following timelines are established with regard to provider enrollment;

1. Mail provider enrollment packets within two (2) business days of request.
2. Process provider applications and updates within five (5) business days of receipt.
3. Notify providers of acceptance/rejection within ten (10) business days of receipt of the application. This notification includes information regarding the provider's program billing, NPI, and other information as the State may require.

4. Supply provider with SCPCS code listings within five (5) business days of request.

5. Update institutional rates on the provider master file within two (2) business days of receipt.

6. Provide minutes of provider enrollment meetings to the State within ten (10) business days.

Consumers of HCBS-i/DD 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 the KanCare program; about transition planning (and specific flexibility to support this) 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

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

KanCare Managed Care Organization (MCO) reports and record reviews

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<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 checked="" type="checkbox"/> Other Specify: KanCare MCOs 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

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

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Managed Care Organization (MCO) Reports and and record reviews

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<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 checked="" type="checkbox"/> Other Specify: KanCare MCOs 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:

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

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Managed Care Organization (MCO) Reports and record reviews

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 checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	

		<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input checked="" type="checkbox"/> Other Specify: KanCare Managed Care Organizations (MCOs)	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Proportionate by MCO
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<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 checked="" type="checkbox"/> Other Specify: KanCare MCOs 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:

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Managed Care Organization (MCO) reports and record reviews

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<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 checked="" type="checkbox"/> Other Specify: KanCare MCOs 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: _____

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:

Number and percent of active providers that meet training requirements

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Managed Care Organization (MCO) Reports and record reviews

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

	<input type="checkbox"/> Other Specify: _____
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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 type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: KanCare MCOs 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: _____

- 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.

State staff (Regional Field Staff – Quality Assurance) verify service providers meet required licensure and certification standards and compliance with licensure requirements prior to furnishing waiver services. Review of Qualified Providers is conducted through the On-site Monitoring Process. The On-site Monitoring Process identifies services and supports to be provided by licensed and non-licensed service providers to meet regulatory, waiver, and performance standard assurances. The development of the Quality Survey process is based on a uniform, standard assessment instrument and is implemented and utilized statewide. Performance standards are monitored by state staff (Regional Field Staff – Quality Assurance) through the Quality Survey process. This function is performed through on-site reviews and on-going assurance of compliance with regulations and applicable performance standards including: Individualized Plan of Care review, Individual Behavior Support Planning, License, Education, and Certification Review, Background Check Review, Record reviews, on-site, Training verification records, On-site observations, interviews, monitoring, Analyzed collected data, Trends, remediation actions proposed and taken, Provider performance monitoring, Staff observation, Participant and family observation and interview, Critical incident report monitoring, Child Protective Services Reports and findings, Death reporting, Program data review, Medication administration data report and log review. As further discovery, State Staff conduct individualized consumer, family interviews to identify assurances of appropriate supports and services to meet each individual’s needs and review to assure accuracy with regard to the identified needs of the individual.

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.

Data gathered through the Quality Survey Process is compiled, reviewed, and trended on a quarterly by the data analysis unit. 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.

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 Managed Care Organizations (MCOs)	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

c. Timelines

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

- No**
- Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c)

how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Person Centered Support Plan

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

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

Specify qualifications:

Case management services for people on the I/DD HCBS Waiver are provided by individuals employed by entities annually licensed by the Kansas Department for Aging and Disabilities Services that are also enrolled Medicaid providers for Developmental Disabilities Targeted Case Management services. Each individual case manager is required to have met the following education and training requirements:

- Six months full time experience in a field of human services; and
- A bachelor degree or additional full-time experience in the field of developmental disabilities services, which may be substituted for the degree at the rate of 6 months of full-time experience for each missing semester of college; and
- Successful completion of the designated case management training and assessment by scoring eighty five percent or higher on each module.

Regarding Amerigroup: Service Coordinators must have at least two years of experience working with individuals with chronic illness, comorbidities, and/or disabilities in a Service Coordinator, Case Management,

Advocate or similar role. A Masters degree is preferred however, education/experience for Service Coordinators must include one of the following

- Bachelors degree from an accredited college or university in Nursing, Social Work, Counseling, Special Education, Sociology, Psychology, Gerontology, or a closely related field, or State Waiver;
- Bachelors Degree in an unrelated field and at least two years of geriatric experience; or
- In lieu of a bachelor's degree, six years of case management experience.

Regarding Sunflower: Sunflower employs an Integrated Care Team approach for Service Plan Development. Teams assisting with the development of comprehensive plans of care for members are generally comprised of multidisciplinary clinical and nonclinical staff. Care managers are Registered Nurses and Master's level Behavioral Health clinicians with care management experience and, as applicable to the position, expertise including adult and pediatric medical, maternity and behavioral health/psychiatric care.

Regarding United: Service plans are developed by licensed nurses or licensed social workers.

Social Worker.

Specify qualifications:

Other

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

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

* The State employs 26 KDADS Regional Field Staff. These individuals are assigned specific CDDO service areas around the State and are responsible for assuring that individuals receive quality services. This is done through ongoing observation, monitoring and feedback of the services provided by the community service provider.

Local CDDOs are also responsible for the development and implementation of local Quality Assurance processes that includes participation of providers, parents/guardians and consumers of services. These local CDDO review committee's work collaboratively with the 26 KDADS Regional Field Staff.

* The Regional Field Staff, on a quarterly basis, review the services of a sample of waiver consumers through the Kansas Lifestyle Outcomes II survey process. This process identifies outcomes related to service provision and whether those outcomes are being met by the entity responsible for the provision of services.

* The Targeted Case Manager develops a person centered support plan or plan of care based a variety of resources including the DDP, a needs assessment and information gathered from people who know and care about the person receiving services. The person centered plan is an individualized plan that identifies the needs, supports, and services necessary and are developed in partnership with the individual, and if appointed, the legal guardian.

* The individual is supported in making informed choices regarding;

*Services and supports

*Self-direction (employer and/or budget options, if available) [Individuals that choose the self-direct option are provided opportunities for training to more effectively handle their self-directing responsibilities. Also, these persons are provided support in understanding the benefits / rights /limitations and the

responsibilities and the potential liabilities of self-direction. Liabilities may include not having staff at all times, due to staff recruiting, retention or availability issues that are the individual's responsibility under self direction.]

*Providers, agencies, and case managers. The person is supported in making independent choices of self-direction or among providers regardless of the affiliation of the case manager.

* Choice is offered at least annually, regardless of current provider or if the person has self-direction, or at other life choice decision points, or any time at the request of the individual. Individuals are provided information about the full range of waiver services by CDDOs and by MCO care management staff.

* Choice is documented with the consumer signature and place for review in the individual case file.

* The Plan of Care, Person-centered Support Plan and choice documentation is monitored by KDADS Regional Field staff and the KanCare MCOs as a component of waiver assurance and minimum standards.

* The Plan of Care and Person-centered Support Plan which are modified to meet change in needs, eligibility, or preferences, or at least annually.

The KanCare MCOs will work with the member, the member's TCM and the other participants in the member's support planning team, to assist in the development of a comprehensive plan of care that addresses the service and support needs across the member's life and to assist the member in identifying and accessing services and supports beyond the I/DD waiver services. This will be a part of the KanCare MCOs' administrative functions around care coordination and member support within the KanCare program.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Consistent with the Developmental Disabilities Reform Act of 1995 and further with K.A.R. 30-63-21, the provider (s) of services shall prepare a written person-centered support plan for each person served that shall meet the following requirements;

The relevant requirements are;

1. Be developed only after consultation with the following;
 - A) The person;
 - B) The persons' legal guardian, if one has been appointed, and;
 - C) Other individuals from the persons' support network as the person or the persons' guardian chooses.
2. Contain a description of the persons' preferred lifestyle.
3. The plan must list and describe the necessary activities, training, materials, equipment, assistive technology and services that are needed to assist the person to achieve the person's preferred lifestyle. the person's case manager will be responsible for coordination of the plan.

All participants have the opportunity, to the extent he/she chooses, to participate in the development of his/her person-centered plan. The CDDO is responsible for informing the participant of the types of waiver services available in the CDDO are and a list of all of the providers of those services. The participant's case manager is responsible for and assisting the participant in his/her effort to meet with waiver providers to discuss how the provider can meet the participants' needs. In addition, the case manager is responsible for informing the consumer of training opportunities that are available to assist the participant in becoming more active in his/her role in the planning process to the extent that he/she chooses.

Training topics would include but are not limited to;

- Person-centered planning models
- Self-Advocacy and;
- Rights and Responsibilities

A complete copy of K.A.R. 30-63-21 is available to CMS upon request.

The KanCare MCOs will work with the member, the member's TCM and the other participants in the member's support planning team, to assist in the development of a comprehensive plan of care that addresses the service and support needs across the member's life and to assist the member in identifying and accessing services and supports beyond the I/DD waiver services. This will be a part of the KanCare MCOs' administrative functions around care management and member support within the KanCare program.

The Person-Centered Planning process includes the development of the Person-Centered Plan, Individualized Education Plan, Behavior Management and Support Plan, Emergency Backup Plan, and other plans that are designed to identify the needs of an individual and determine the appropriate level of supports and services to meet those

needs. Information from the person-centered planning process will be incorporated in the MCO's Integrated Service Plan of Care. The process also includes the development of future goals and indication of preferred lifestyle choices, which are identified and included in the Person Centered Support Plan, which is developed by an individual's Targeted Case Manager (TCM) in conjunction with the individual and their support team, including the individual's MCO.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

For persons applying for HCBS-I/DD services, The Developmental Disabilities Reform Act (DDRA) identifies the CDDO as the entity responsible to either directly or by subcontract, have a process for determining individuals eligible/ineligible for;

1. I/DD services: Persons must first be identified as a person diagnosed with an intellectual disability consistent with the DDRA definition or a person meeting the definition of developmental disability as defined by the DDRA, then;

2. If the person is found to meet either of these definitions, the CDDO (or its designee as defined by local policy) will conduct a BASIS Assessment. The BASIS Assessment consists of 3 parts, with part two being the Developmental Disability Profile (DDP). The DDP has been used by the State of Kansas as the waiver eligibility determination tool since the waiver was initially approved many years ago. During this assessment process, the participant, his/her guardian (if one has been appointed), case manager and any other person who may know and care about the participant are invited to be a part of the process. A minimum converted score of 35 on the DDP is required for the person to be eligible for HCBS-I-DD Services. In addition, children between the ages of 5 and 10 must achieve a minimum score of 21 on a children's assessment.

Through information gleaned from reports and information provided by the people identified above, the DDP screener completes the assessment which includes questions regarding the participant's needs, preferences and goals as well as health status. The DDP assessment is then completed annually, during the participant's birth month, to re-determine continued eligibility for the HCBS-I/DD waiver.

3. After being determined eligible, the participant's case manager will develop a person-centered plan for the participant that will identify service needs and goals and will educate the participant on what the array of available waiver services are, and identify which services will best meet those identified needs and goals. The CDDO is responsible for assuring the consumer is aware of all of the service provider options available in the local area. This process is more detailed in Appendix D-1f.

4. In collaboration with the MCO care coordinator, a Plan of Care (POC) is then developed. The POC identifies the support needs, as well as who is responsible for meeting those needs, the specific amount of services that will be approved to meet those needs and also the amount of funds that the provider(s) will be reimbursed to meet those needs. Once the Plan of Care is approved, the participant can begin receiving services.

5. The process for the on-going monitoring of the provision of services is identified in section D-2a.

6. Plans of Care are updated at a minimum of every 12 months, during the participant's birth month. The case manager and MCO care coordinator are responsible for the on-going review of the plan to assure it meets the health and welfare needs of the participant. Changes in conditions that may prompt the need for changes to the services provided are identified by the case manager and service revisions are submitted to the CDDO for review.

7. The Targeted Case Manager and MCO care coordinator are responsible for the coordination of formal/informal supports and assuring that the consumer has access to needed State Plan services such as medical and home health services, TANF benefits and employment referral to Vocational Rehabilitation Services.

8. All cited documents in this section are available for CMS review upon request.

The KanCare MCOs will work with the member, the member's TCM and the other participants in the member's support planning team, to assist in the development of a comprehensive plan of care that addresses the service and support needs across the member's life and to assist the member in identifying and accessing services and supports beyond the I/DD waiver services. This will be a part of the KanCare MCOs' administrative functions around care

management and member support within the KanCare program.

The BASIS assessment is completed by the assessor at least annually or as needed when needs change. The assessors are expected to generate a monthly report that will indicate outstanding assessments, which will be added to their workload and completed within 30 days. The State will conduct quality assurance on this process. The TCM and MCO Care Coordinator will complete additional assessments as necessary to assure individuals identified needs are met.

Changes in condition or circumstances that prompt a need for changes to services and supports provided are identified by the individual, guardian and/or the targeted case manager (TCM). The TCM and MCO will conduct appropriate assessment of need within 10 days of notification of the request to determine if additional services and supports are required to meet the individual's needs. The TCM and MCO will develop a new or modified Integrated Service Plan (ISP) with the member, if the member is assessed as needing the additional services and supports, or the MCO will deny the request and the individual will be provided with a Notice of Action with appeal rights. (See attached workflow). If the MCO and TCM disagree in the assessment of need for a waiver service requested by a member on the "underserved" list, KDADS will review the amount, duration and type of support or service being offered to meet an individual's need and make a determination.

After KDADS reviews the amount, duration and type of support or service being offered to meet an individual's need, it will make the decision when the MCO and TCM disagree in the assessment of need for a waiver service.

The BASIS, person-centered plan and statewide needs assessment are utilized to identify the level of need and support an individual would need as part of their service plan. The State will utilize its existing quality review protocols and tools to ensure that the process is consistent and predictable and individuals' needs are met.

The State does not intend to develop a new assessment tool for this process. The state will use existing quality assurance tools and processes to assure individual's needs are being met and the assessments tools are being administered and applied appropriately.

An individual is provided a Notice of Action with appeals rights when they are denied a requested service or a service is reduced. The Notice of Action must identify the reason for the denial, the right to file a grievance or appeal, and the right to a State Fair Hearing within 30 days of the date provided on the letter (3 additional days are allowed for notices that are mailed).

Appendix D: Participant-Centered Planning and Service Delivery

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

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

K.A.R. 30-63-21 requires the provider, as part of it's development of the person-centered support plan, to assist the person or the person's guardian to understand the negative consequences of choices the provider knows the person might make and that may involve risk to that person. Further, the plan shall describe when it is necessary to do so, how the preferred lifestyle might be limited because of imminent significant danger to the persons health, safety, or welfare based on as assessment of the following;

- * The person's history of decision-making, including any previous experience or practice the person has in exercising autonomy, and the persons' ability to learn from the natural negative consequences of poor decision-making;
- * The possible long and short-term consequences that might result to the person if the person makes a poor decision;
- * The possible long and short-term effects that might result to the person if the provider limits or prohibits the person from making a choice; and
- * The safeguards available to protect the person's safety and rights in each context of choices.

As a part of the person-centered planning process, each provider of services for an individual shall discuss, and incorporate into the person-centered plan, any identified risks associated with leaving a person unsupervised. Appropriate times for supervision shall be identified and the provider will include it's strategies to assure persons are not placed at risk when/ backup strategies need to be implemented.

Providers of licensed services such as Residential Supports and Day Supports are required in their policies and procedures to have the necessary backup plans in place such as emergency and disaster plans to assure the persons

health and welfare. In addition, these providers must have plans to assure necessary back-up staff is available in the event that scheduled staff cannot make it to work.

For those who self-direct their services, a backup plan that is developed and monitored by the case manager must be in place to assure the person receives the necessary supports to assure his/her health and welfare. This plan may include both the use of paid and natural supporters.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The Developmental Disabilities Reform Act of 1995 specifies in section 39-1805 the duties of a Community Developmental Disability Organization to provide either directly or by subcontract, services to persons with a developmental disability including but not limited to, among other things, an explanation to the participant of the available services and service providers in the CDDO area.

Persons receiving services will be advised of the available community service providers in the CDDO area on at least an annual basis and also when requested by the person. This may be done in a variety of ways including lists which are updated on a regular basis or through the CDDOs website.

Once a participant is made aware of the services available and the providers of services in the area, the persons' case manager will assist him/her in meeting with and touring services provided. It becomes the case manager's role to facilitate, the person and the persons' guardian if one has been appointed, through a process that ends with the participant choosing a provider of services that can meet the persons' support needs.

KDADS will provide a provider capacity map by CDDO catchment area that demonstrates access to services and provider capacity to meet identified needs. If a need for additional capacity is identified, the CDDO will provide a capacity development plan and work with the MCO to provide incentives to attract new providers as necessary. If needed, the MCO will provide alternate temporary services while that capacity is developed.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The individual's targeted case manager (TCM) develops a person-centered support plan and behavior support plan and submits it to the care coordinator (MCO case manager also referred to as a service coordinator) for review and inclusion in the Integrated Service Plan, which includes a plan of care for HCBS waiver supports and services, behavioral health services, and physical health services. The MCO approves the Integrated Service Plan, and then it is shared electronically with the CDDO, TCM, and providers so that services can begin. The Medicaid Agency has oversight responsibility of this process.

A paper plan of care is to be maintained in the participant's file. This plan should match the electronic plan of care. The Medicaid Agency monitors the following through a review of data provided by KDADS that is obtained through the Quality Management Strategy:

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

A critical component of that strategy is the engagement of the KanCare Interagency Monitoring Team, which will meet quarterly and bring together leadership, program management, contract management, fiscal management and other staff/resources of the SSMA and the Operating Agency to collectively monitor the extensive reporting, review results and other quality information and data related to the KanCare program and services.

KDADS meets on a monthly basis with the Medicaid Agency to discuss the waiver, including proposed policies and waiver amendments. On a quarterly basis, at the monthly meeting, the data obtained through the quality review

process is presented to the Medicaid Agency. A portion of the data collected is obtained through a review of service plans to determine if the plan is meeting the needs of the participant while meeting the health and welfare needs of the individual.

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Specify the other schedule:

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

- Medicaid agency
- Operating agency
- Case manager
- Other

Specify:

Service plans and related documentation will be maintained by the consumer's chosen KanCare MCO, local Community Developmental Disability Organization and the persons' Community Service Providers and will be retained at least as long as this requirement specifies.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

The SMA and operating agency has overall responsibility for monitoring the service plans. The SMA has delegated direct monitoring of service plan to the MCOs to oversee provisions related to the services furnished in accordance with the service plan, participant access to waiver services as identified in the service plan, participants ability to choose a provider of choice, services meet participants' identified needs, effectiveness of back-up plans, participant health and welfare, participant access to non-waiver services in service plan, including health services.

The three KanCare contracting managed care organizations are responsible for monitoring the implementation of the Plan of Care that was developed as a partnership between the participant, TCM and the MCO and for ensuring the health and welfare of the consumer with input from the I/DD Program Manager, involvement of KDADS Regional Field Staff, and assessed with the comprehensive statewide KanCare quality improvement strategy (which includes all of the HCBS waiver performance measures).

On an ongoing basis, the MCOs monitor the Plan of Care and consumer needs to ensure:

- Services are delivered according to the Plan of Care;
- Consumers have access to the waiver services indicated on the Plan of Care;

- Consumers have free choice of providers and whether or not to self-direct their services;
 - Services meet consumers needs;
- Liabilities with self-direction/agency-direction are discussed, and back-up plans are effective; Consumer's health and safety are assured, to the extent possible; and consumers have access to non-waiver services that include health services.

The Plan of Care is the fundamental tool by which the State will ensure the health and welfare of consumers served under this waiver. The KanCare MCOs, who deliver no direct waiver services to waiver participants, are responsible for both the initial and updated integrated plans of care.

In-person monitoring by the MCOs is ongoing:

- Choice and monitoring are offered at least annually, regardless of current provider or self-direction, or at other life choice decision points, or any time at the request of the consumer.
- Choice is documented.
- The Plan of Care is modified to meet change in needs, eligibility, or preferences, or at least annually.

In addition, the Plan of Care and choice are monitored by state quality review and/or performance improvement staff as a component of waiver assurance and minimum standards. Issues found needful of resolution are reported to the MCO and waiver provider for prompt follow-up and remediation. Related information is reported to the I/DD Program Manager.

Service plan implementation and monitoring performance measures and related 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 HCBS waiver program 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/provider 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 which includes KDHE.

The CDDOs may assist the participant in identifying service providers in their region who may provide the type of service the participant is seeking.

b. Monitoring Safeguards. Select one:

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

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

Established safeguards include informal on-going review processes in place and conducted by KDADS Regional Field Staff, and more formal review through the Kansas Lifestyle Outcomes II process, but the primary responsibilities with the KanCare MCOs and the persons' case manager who are both prohibited from providing any direct service to the participant. In addition, the safeguards in place for all other Medicaid providers apply to all Medicaid-enrolled Financial Management (FMS) agencies.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

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

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

Responsible Party for data	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>

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

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of waiver participants whose service plans address health and safety risk factors N=Number of waiver participants whose service plans address health and safety risk factors D=Number of waiver participants whose service plans were reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

Number and percent of waiver participants whose service plans address participants' goals
N=Number of waiver participants whose service plans address participants' goals
D=Number of waiver participants whose service plans were reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

Responsible Party for data	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>

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

Data Aggregation and Analysis:

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

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

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:

Number and percent of waiver participants whose service plans were developed according to the processes in the approved waiver
 $N = \text{Number of waiver participants whose service plans were developed according to the processes in the approved waiver}$
 $D = \text{Number of waiver participants whose service plans were reviewed}$

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

Responsible Party for data	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<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 the 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:

Performance Measure:

Number and percent of waiver participants (or their representatives) who were present and involved in the development of their service plan N = Number of waiver participants (or their representatives) who were present and involved in the development of their service plan D = Number of waiver participants whose service plans were reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<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 the 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:

c. *Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant’s needs.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 service plans reviewed before the waiver participant's annual redetermination date N=Number of service plans reviewed before the waiver participant's annual redetermination date D=Number of waiver participants whose service plans were reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

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

<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input checked="" type="checkbox"/> Other Specify: KanCare Managed Care Organizations (MCOs)	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Proportionate by MCO
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: _____
	<input type="checkbox"/> Other Specify: _____	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<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 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: _____

Performance Measure:

Number and percent of waiver participants with documented change in needs whose service plan was revised, as needed, to address the change N=Number of waiver participants with documented change in needs whose service plan was

revised, as needed, to address the change D=Number of waiver participants whose service plans were reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<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 of this measure's results	<input checked="" type="checkbox"/> Annually

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
as determined by the State operating agency	
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 received services in the type, scope, amount, duration, and frequency specified in the service plan N=Number of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan D=Number of waiver participants whose service plans were reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record Reviews and Electronic Visit Verification (EVV) Reports

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

KanCare Managed Care Organizations (MCOs)		Describe Group: Proportionate by MCO
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of survey respondents who reported receiving all services as specified in their service plan N=Number of survey respondents who reported receiving all services as specified in their service plan D=Number of waiver participants interviewed by QMS staff

Data Source (Select one):

Other

If 'Other' is selected, specify:

Customer Interviews - on site

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

<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: _____	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Proportionate by MCO
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: _____
	<input type="checkbox"/> Other Specify: _____	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<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 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: _____

e. *Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<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 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: _____

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

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

	<input type="checkbox"/> Other Specify: _____	

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of waiver participants whose record contains documentation indicating a choice of community-based services v. an institutional alternative N = Number of waiver participants whose record contains documentation indicating a choice of community-based services D = Number of waiver participants whose files are reviewed for the documentation

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record Reviews

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

		Confidence Interval = 95%
<input checked="" type="checkbox"/> Other Specify: KanCare Managed Care Organizations	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Proportionate by MCO
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<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 the 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:

Performance Measure:

Number and percent of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care N = Number of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care D = Number of waiver participants whose files are reviewed for the documentation

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record Reviews

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):

- 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.

State staff (Regional Field Staff – Quality Assurance) verify service providers meet required licensure and certification standards prior to furnishing waiver services through the Policy Approval Process. Review of Qualified Providers is conducted through the On-site Monitoring Process and was developed in Kansas by consumers, stakeholders, and the Waiver Operating agency. The On-site Monitoring Process identifies all services and supports to be provided by licensed and non-licensed service providers to meet regulatory, waiver, and performance standard assurances. The development of the Quality Survey process is based on a uniform, standard assessment instrument and is implemented and utilized statewide by state staff. Performance standards are monitored by state staff (Regional Field Staff – Quality Assurance) through the Quality Survey process. This function is performed through on-site reviews and on-going assurance of compliance with regulations and applicable performance standards; including Individualized Plan of Care review / Individual Behavior Support Planning / License, Education, and Certification Review / Background Check Review / Record reviews, on-site / Training verification records / On-site observations, interviews, monitoring / Analyzed collected data(including surveys, focus groups, interviews) / Trends, remediation actions proposed and taken / Provider performance monitoring / Staff observation and opinion / Participant and family observation and interview / Critical event and incident report monitoring / Child Protective Services Reports and findings / Death reporting / Program data review / Medication administration data report and log review. As further discovery, State Staff conduct individualized consumer / family interviews to identify assurances of appropriate supports and services to meet each individual’s needs and review to assure accuracy with regard to the identified needs of the individual.

Data gathered through the Quality Survey Process is compiled, reviewed, and trended through the following Performance Improvement Analysis Process which occurs on an annual basis.

1. Performance Improvement Data Aggregation (Central Office Performance Improvement Program Manager)
2. Performance Improvement Analysis Process including:
 - a. Community Choice Reflection Team (100% consumer members) review of statewide data versus local provider trends)
 - b. Performance Improvement Review Committee (Central Office PI Program Manager and Regional KDADS field staff)
 - c. Performance Improvement Executive Review Committee (Central Office Assistant Director, Performance Improvement Program Manager and waiver program managers.)
3. Performance Improvement Waiver Report provided to the Kansas Department of Health and Environment via the KDHE Long Term Care Committee, for review by the State Medicaid Agency (SSMA).

b. Methods for Remediation/Fixing Individual Problems

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

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

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

- ii. **Remediation Data Aggregation**

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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<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 checked="" type="checkbox"/> Other Specify: KanCare Managed Care Organizations (MCOs)	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: _____

c. Timelines

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

- No**
- Yes**

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

CAP to Address: Elimination of Requested Services (“Underserved”) Wait List

Regulatory/Statute/Policy: Olmstead Letter #4 SMDL #01-006 dated 1/10/2001

Goal Statement:

- All waiver participants with unmet/unassessed needs who are in the underserved wait list as of December 31, 2013, will have all current assessed service needs met.
- Must comport with Appendix D-1-c

CAP Conclusion Statement:

CAP will be completed when all individuals on the underserved wait list have received assessment/reassessment and are receiving currently needed services in the 1915(c) waiver as these needs are identified, with all assessments and services in place within 180 days of IDD services being included in KanCare or, if denied or are approved in a lesser duration, amount or scope than that requested, have received notice and opportunity to exercise full due process and appeal rights.

Measurable Tasks:

Action Step1: Public Communications

Completion Target Date: January 31, 2014

Responsible Entity (ies): KDADS

Milestones:

1. Consumers will be provided clear information regarding the upcoming changes to the waiting list that has been historically maintained for requested services.
2. Survey IDD providers on estimated capacity to serve individuals who are requesting an additional service. Survey responses will be due within 15 days. KDADS will provide a provider capacity map by CDDO catchment area.
3. KDADS will send an inquiry to IDD Participants (or guardians) who are receiving some, but not all, 1915(c) waiver services and are currently identified on a statewide list as requesting services. Consumers can return a self-attestation that they do not have a current need for the requested additional service within 30 days of the date the letter is sent.

Deliverables: KDADS will provide a copy of the

1. Policy Letter regarding elimination of the wait list for additional services
2. Provider Capacity Survey
3. Consumer Letter to persons requesting additional services
4. Written description of plan to increase provider capacity where needed

Action Step 2: Meet Current Needs

Completion Target Date: Within 6 months of KanCare delivery of IDD services

Responsible Entity (ies): KDADS, KDHE, MCO, TCM

Milestones:

1. Within six months of IDD services becoming part of the KanCare program, an updated person centered support plan will be developed, including a renewed assessment of needs, and effective ways to meet those needs, for those on the “underserved waiting list” who do not return a self-attestation form that indicates their service request is for the future. This update will follow the process reflected on the state’s flow chart and will determine if the requested services meet criteria for need.
2. For those who are assessed to have a current need for additional services, the MCOs will both approve and provide the additional services in the amount, duration and scopes requested, or deny and provide opportunity to exercise full due process rights. MCOs will be expected to ensure access and provider capacity. If needed, the MCO will provide alternate temporary services while provider capacity is developed.
3. The State will ensure all individuals on the underserved waiting list receive a Notice of Action with appeals rights, by incorporating a review into existing quality review processes. The State will review and approve Notice of Action templates to ensure understandable and required language is included in all notices sent by the MCO or other contracted entities. In addition, State Quality Review teams will review notices of action sent to a sample of members to ensure individuals are receiving timely notices of denials or reductions in services, which include State Fair Hearing notices.
4. Assessment and service planning will follow the processes identified in the flow chart prepared by the state entitled “End to End Access to DD Service Process” last dated 12/31/13.

Deliverables:

1. Completion of updated person centered support planning for all individuals on the underserved list who does not attest to only a future need for the additional services.
2. Provision of the additional services in the amount, duration and scope requested and update to the Person-Centered Support Plans and Integrated Support Plans, or provide opportunity to exercise due process and appeal rights.
3. Weekly progress reports on the action steps, milestone attainment and deliverables completed to date.

Deliverable Completion Target Date Responsible Entity Status Updates Date Completed

Policy Letter about waitlist management and changes 1/15/2014 KDADS

Provider Capacity Letter (15 day response time) 1/15/2014 KDADS

Provider Capacity Responses due 1/30/2014 KDADS

Consumer Letter & Self-Attestation Form to persons requesting additional services sent (response due in 30 days) 1/31/2014 KDADS & KDADS IT

Public Information Sessions 2/15/2014 KDADS

Provider Licensing, Contracting, Credentialing and Affiliating Ongoing KDADS, MCOs, CDDOs

Verification Form/Self-Attestation deadline 3/2/2014 KDADS

Complete Assessments for Current Need (those who do not return form and/or self-attest to future need) (# to complete: 50-200 in February, 100-300 March, April, May and June.) 6/1/2014 MCO/TCM

Services for current need authorized or NOA sent As assessed, all complete by 6 months from start of IDD services in managed care MCO/TCM

Alternate temporary services provided while provider capacity is developed if needed As assessed MCO

Appendix E: Participant Direction of Services

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

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

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

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

a) Participants are informed that, when choosing participant direction (self direction) of services, they must exercise responsibility for making choices about attendant care services, understand the impact of the choices made, and assume responsibility for the results of any decisions and choices they make. Participants are provided with, at a minimum, the following information about the option to self direct services:

- the limitation to Personal Service Attendants;
- the need to select and enter into an agreement with an enrolled Financial Management Services (FMS) provider;
- related responsibilities (outlined in E-1-a);
- potential liabilities related to the non-fulfillment of responsibilities in self-direction;
- supports provided by the managed care organization (MCO) they have selected;
- the requirements of personal service attendants;
- the ability of the participant to choose not to self direct services at any time; and
- other situations when the MCO may discontinue the participant's participation in the self-direct option and recommend agency-directed services.

b) The MCO is responsible for sharing information with the participant about self direction of services by the participant. The FMS provider is responsible for sharing more detailed information with the participant about self-direction of services once the participant has chose this option and identified an enrolled provider. This information is also available from the I/DD Program Manager and KDADS Regional Field Staff.

c) Information regarding self-directed services is initially provided by the MCO during the plan of care/service plan process, at which time the Participant Choice form is completed and signed by the participant, and the choice is indicated on the participant's Plan of Care. This information is reviewed at least annually with the member. The option to end self direction can be discussed, and the decision to choose agency-directed services can be made at any time.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

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

- Both Authorities.** The waiver provides for both participant direction opportunities as specified in *Appendix E-2*. Supports and protections are available for participants who exercise these authorities.

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

- Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

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

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

Per the contract between KDADS and the Community Developmental Disability Organizations (CDDOs), each CDDO will ensure that persons seeking or receiving services in the CDDO area have been informed of the benefits and responsibilities of the self-direction option for all or part of the participant's services. Information will be provided in a timely manner to permit informed decision making by the participant and, at a minimum, will be presented to the person annually during his/her eligibility determination process or person-centered plan review, or at any time requested by the participant or the person directing services on behalf of the participant.

In addition to the CDDO, the MCO is also responsible for sharing information with the consumer about self direction of services by the consumer. Information regarding self-directed services is initially provided by the MCO during the plan of care/service plan process, at which time the Consumer Choice form is completed and signed by the consumer, and the choice is indicated on the consumer's Plan of Care. This information is reviewed at least

annually with the member. The option to end self direction can be discussed, and the decision to choose agency-directed services can be made at any time.

Information regarding participant direction, including potential liabilities associated with participant direction, is available to all participants through the KDADS website and copies of the K-PASS self-direction tool kit are available to participants through the local CDDO or KDADS.

The Self-Directing Individual and individual's representative are responsible for working collaboratively with their FMS provider to meet shared objectives. These objectives include:

- Self-Directing Individuals receive high quality services.
 - Self-Directing Individuals receive needed services from qualified workers.
 - Tasks are provided in accordance with state law governing self-direction, Medicaid and the State of Kansas requirements, and are approved and authorized in the POC.
- The Self-Directing Individual or individual's representative has the responsibility to:
 1. Act as the employer for Direct Support Workers, or designate a representative to manage or help manage Direct Support Workers.
 2. Negotiate a FMS Service Agreement with the chosen FMS provider that clearly identifies the roles and responsibilities of the individual and the AWC FMS provider
 3. Select Direct Support Worker(s).
 4. Refer Direct Support Workers to the FMS provider for completion of required human resources and payroll documentation. In cooperation with the FMS provider, all employment verification and payroll forms must be completed.
 5. Negotiate an Employment Service Agreement with the Direct Support Worker that clearly identifies the responsibilities of all parties.
 6. Provide or arrange for appropriate orientation and training of Direct Support Worker(s).
 7. Determine schedules of Direct Support Worker(s).
 8. Determine tasks to be performed by Direct Support Worker(s) and where and when they are to be performed in accordance with the approved and authorized POC /PSCP/ ACW/CSW and/ or others as identified and/or are appropriate.
 9. Manage and supervise the day-to-day HCBS activities of Direct Support Worker(s).
 10. Verify time worked by Direct Support Worker(s) was delivered according to the POC; and approve and sign timesheets.
 11. Assure submission of Direct Support Worker timesheets and all other required documents to the FMS provider for processing and payment in accordance with established FMS, State, and Federal requirements. The timesheet will be reflective of actual hours worked in accordance with an approved POC.
 12. Report work-related injuries incurred by Direct Support Worker(s) to the FMS.
 13. Develop an emergency worker back-up plan in case a substitute Direct Support Worker is ever needed on short notice or as a back-up (short-term replacement worker).
 14. Assure all appropriate service documentation is recorded as required by the State of Kansas HCBS Waiver program policies, procedures, or by Medicaid Provider Agreement.
 15. Inform the FMS provider of any changes in the status of Direct Support Worker(s), such as changes of address or telephone number, in a timely fashion.
 16. Inform the FMS provider and Targeted Case Manager of the dismissal of a Direct Support Worker within 3 working days.
 17. Inform the FMS provider and Targeted Case Manager of any changes in the status of the individual or individual's representative, such as the individual's address, telephone number or hospitalizations within 3 working days.
 18. Participate in required quality assurance visits with Targeted Case Managers, and State Quality Assurance Staff, State Quality Management Specialist (QMS), or other appropriate and authorized reviewers / auditors.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

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

- The State provides for the direction of waiver services by representatives.**

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

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

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

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

Each participant has a person-centered plan that is developed with input from the person, any identified responsible party, and person's who know and care about the participant. In the event that a non-legal representative has been chosen by an adult participant, the support team, along with the participant will identify the roles and responsibilities of the non-legal representative and these roles and responsibilities will be documented in the person-centered plan. At any time the person-centered plan is being reviewed and updated, the performance of the non-legal representative will be reviewed to assure that the person is functioning in the best interest of the participant and a determination will be made as to any needed changes or modifications to the role of the non-legal representative. It is the role of the Targeted Case Manager and the KanCare MCO to assure services are provided in a manner consistent with the person-centered plan.

KanCare MCOs will work with the member, the member's TCM and the other participants in the member's support planning team, to assist in the development of a comprehensive plan of care that address the service and support needs across the member's life and to assist the member in identifying and accessing services and supports beyond the I/DD waiver services.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Personal Assistant Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Overnight Respite Care	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Sleep Cycle Support	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Financial Management Services (FMS)	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

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

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

Governmental entities

Private entities

- No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.**
Do not complete Item E-1-i.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

- FMS are covered as the waiver service specified in Appendix C1/C3**

**The waiver service entitled:
Financial Management Services**

- FMS are provided as an administrative activity.**

Provide the following information

- i. Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

Enrolled FMS providers will furnish Financial Management Services using the Agency with Choice provider model. The provider requirements will be published and placed on the Kansas Medical Assistance Program (KMAP) website and/or in the KanCare MCO provider manuals and websites.

Organizations interested in providing Financial Management Services (FMS) are required to submit a signed Provider Agreement to the State Operating Agency, KDADS, prior to enrollment to provide the service. The agreement identifies the waiver programs under which the organization is requesting to provide FMS and outlines general expectations and specific provider requirements. In addition, organizations are required to submit the following documents with the signed agreement:

- Community Developmental Disability Organization (CDDO) agreement (DD only)
- Secretary of State Certificate of Corporate Good Standing
- W-9 form
- Proof of Liability Insurance
- Proof of Workers Compensation insurance
- Copy of the most recent quarterly operations report or estimate for first quarter operations
- Financial statements (last 3 months bank statements or documentation of line of credit)
- Copy of the organization's Policies and Procedures manual, to include information that covers requirements listed in the FMS Medicaid Provider Manual.

The FMS provider agreement and accompanying documentation are reviewed by the State Operating Agency and all assurances are satisfied prior to signing by the Secretary of KDADS (or designee). KanCare MCOs should not credential any application without evidence of a fully executed FMS Provider agreement.

- ii. Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

FMS providers will be reimbursed a monthly fee per consumer.. The per member per month payment was estimated based upon a formula that included all direct and indirect costs to payroll agents and an average hourly rate for direct care workers. Information was gathered as part of a Systems Transformation Grant study conducted by Myers & Stauffer. Under the KanCare program, FMS providers will contract with MCOs for final payment rates, which cannot be less than the current FMS rate.

- iii. Scope of FMS.** Specify the scope of the supports that FMS entities provide (*check each that applies*):

Supports furnished when the participant is the employer of direct support workers:

- Assists participant in verifying support worker citizenship status**

- Collects and processes timesheets of support workers**
- Processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- Other**

Specify:

Supports furnished when the participant exercises budget authority:

- Maintains a separate account for each participant's participant-directed budget**
- Tracks and reports participant funds, disbursements and the balance of participant funds**
- Processes and pays invoices for goods and services approved in the service plan**
- Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- Other services and supports**

Specify:

Additional functions/activities:

- Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- Provides other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

a.) The state verifies FMS providers meet waiver standards and state requirements to provide financial management services through a biennial review process. A standardized tool is utilized during the review process and the process includes assurance of provider requirements, developed with stakeholders and the State Medicaid Agency (Kansas Department of Health and Environment). Requirements include agreements between the FMS provider and the participant, Direct Support Worker and the State Medicaid Agency and verification of processes to ensure the submission of Direct Support Worker time worked and payroll distribution. Additionally, the state will assure FMS provider development and implementation of procedures including, but not limited to, procedures to maintain background checks; maintain internal quality assurance programs to monitor participant and Direct Support Worker satisfaction; maintain a grievance process for Direct Support Workers; and offer choice of Information and Assistance services.

The Division of Legislative Post Audit contracts with an independent accounting firm to complete Kansas' state wide single audit each year. The accounting firm must comply with all requirements contained in the single audit act. The Medicaid program, including all home and community based services waivers, is a required component of every single state audit.

Independent audits of the waiver will look at cost-effectiveness, the quality of services, service access, and

the substantiation of claims for HCBS payments. Each HCBS provider is to permit the Department for Aging and Disabilities Services, its designee, or any other governmental agency acting in its official capacity to examine any records and documents that are necessary to ascertain information pertinent to the determination of the proper amount of a payment due from the Medicaid program. The Surveillance and Utilization Review Unit of the fiscal agent completes the audits of both participants and providers (K.A.R. 30-5-59).

b.) The Operating Agency is responsible for performing and monitoring the FMS review process. State staff will conduct the review and the results will be monitored by Community Supports and Services. A system for data collection, trending and remediation will be implemented to address individual provider issues and identify opportunities for systems change.

The Kansas Department of Health and Environment through the fiscal agent maintains financial integrity by way of provider agreements signed by prospective providers during the enrollment process and contract monitoring activities

c) All FMS providers are assessed on a biennial basis through the FMS review process and as deemed necessary by the State Medicaid Agency.

(d) State staff will share the results of state monitoring and auditing requirements, with the KanCare MCOs, and state/MCO staff will work together to address/remediate any issue identified. FMS providers also must contract with KanCare MCOs to support KanCare members, and will be included in monitoring and reporting requirements in the comprehensive KanCare quality improvement strategy.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

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

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

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

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Personal Assistant Services	<input type="checkbox"/>
Supportive Home Care	<input type="checkbox"/>
Day Supports	<input type="checkbox"/>
Overnight Respite Care	<input type="checkbox"/>
Sleep Cycle Support	<input type="checkbox"/>
Specialized Medical Care	<input type="checkbox"/>
Residential Supports	<input type="checkbox"/>
Supported Employment	<input type="checkbox"/>
Medical Alert Rental	<input type="checkbox"/>

Participant-Directed Waiver Services	Information and Assistance Provided through this Waiver Service Coverage
Wellness Monitoring	<input type="checkbox"/>
Financial Management Services (FMS)	<input checked="" type="checkbox"/>
Assistive Services	<input type="checkbox"/>

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

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

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy (select one).

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

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

The Department for Aging and Disabilities Services contracts with the Self-Advocate Coalition of Kansas to provide training to consumers regarding the self-directed option for service delivery. Each consumer is given contact information for SACK upon request.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

One of the participant's opportunities as well as responsibilities is the ability to discontinue the self-direct option. If the person chooses to discontinue the self-direct option, he/she is to;

- * Notify all providers as well as the Financial Management Services (FMS) entity. The participant is to maintain continuous PCS coverage with the authorization for service;
- * Give a thirty (30) day notice of their decision to the Community Developmental Disability Organization the targeted case manager and the MCO to allow for the coordination of service provision.

The duties of CDDO staff are to;

- * Present the person with the other service options and the providers of those services in the CDDO area.

The duties of the consumer's case manager and the KanCare MCO in collaboration, are to:

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

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

Consistent with K.A.R. 30-63-10, if it is determined by the Community Developmental Disability Organization or the Kansas Department for Aging and Disabilities Services that the person receiving services is or may be at risk of imminent harm to the person's health, safety, or welfare, the person directing and controlling the services shall correct the situation promptly. If the situation is not so corrected, after notice and an opportunity to appeal, funding for the services shall not continue and the consumer will be presented with the other available services options that can meet his/her needs.

The person-centered plan for the participant will include information regarding the transition from self-directed services and the case manager and MCO will collaborate to assist the person with a transition to provider-managed services that will assure the participant's health and welfare during the transition.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority	
Waiver Year	Number of Participants	Number of Participants	
Year 1	2656		
Year 2	2756		
Year 3	2270		
Year 4	2270		
Year 5	2270		

Appendix E: Participant Direction of Services

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

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

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

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

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

Consumers execute an agreement with enrolled providers of Financial Management Services (FMS) to act as co-employers of workers who provide participant-directed waiver services. FMS providers are

those agencies that have completed and maintain in good standing a provider agreement with the State operating agency and a Medicaid provider agreement with the State Medicaid agency through the State's fiscal agent, and a contract with the consumer's KanCare MCO.

FMS provider agencies perform necessary payroll and human resource functions and provide to the participant the supports necessary to conduct employer-related functions, including the selection and training of individuals who will provide the needed assistance and the submission of complete and accurate time records to the FMS provider agency.

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

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

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

Specify how the costs of such investigations are compensated:

Costs to cover the identified background checks are identified in the agreement between the consumer of services and the selected Financial Management Services provider.

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

Specify:

Appendix E: Participant Direction of Services

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

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

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

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

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

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

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

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

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

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

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

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

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

Kansas has contracted with CDDOs to conduct level of care determinations. Decisions made by the CDDOs are subject to state fair hearing review, and notice of that right and related process will be provided by the independent assessors with their decision on the LOC determination/redetermination.

Kansas has contracted with three KanCare managed care organizations (MCOs) who are required to have grievance and appeal processes that meet all relevant federal and state standards, including state fair hearings and expedited appeals. Each MCO has established operational processes regarding these issues, about which they must inform every member. In addition, the State will review member grievances/appeals during the initial implementation of the KanCare program on a daily basis to see if there are issues with getting into care, ability to get prescriptions or ability to reach a live person on the phone. The State will report to CMS the number and frequency of these types of complaints/grievances during the initial transition period, and will continue to monitor this issue throughout the KanCare program.

Each member is provided information about grievances, appeals and fair hearings in their KanCare member enrollment packet.

KanCare members have the right to file a grievance. A grievance is any expression of dissatisfaction about any matter other than an Action. Grievances can be filed in writing or verbally. Grievances will be acknowledged by MCOs in writing within 10 business days of receipt, and a written response to the grievance will be given to the member within 30 business days (except in cases where it is in the best interest of the member that the resolution timeframe be extended).

All KanCare members are advised the following regarding appeals and state fair hearings:

An appeal can only occur under the following circumstances:

- If an Action has occurred. An Action is the denial of services or a limitation of services, including the type of service; the reduction, suspension, or termination of a service you have been receiving; the denial, in whole or part, of payment for a service; or the failure of the health plan to act within established time requirements for service accessibility.
- You will receive a Notice of Action in the mail if an Action has occurred.
- An Appeal is a request for a review of any of the above actions.
- To file an Appeal: You, your friend, your attorney, or anyone else on your behalf can file an appeal.
- An appeal can be filed verbally, but it must be followed by a written request. The Customer Service Center for your health plan can also help you with an appeal.
- An appeal must be filed within 30 calendar days after you have received a Notice of Action.
- The appeal will be resolved within 30 calendar days unless more time is needed. You will be notified of the delay, but your appeal will be resolved in 45 calendar days.

The information regarding continuance of service is available to the participant on the MCO's notice action or the member's handbook.

You have other options for a quicker review of your appeal. Call your health plan for more information.

Fair Hearings

A Fair Hearing is a formal meeting where an impartial person (someone you do not know), assigned by the Office of Administrative Hearings, listens to all of the facts and then makes a decision based on the law.

- If you are not satisfied with the decision made on your appeal, you or your representative may ask for a fair hearing. It must be done in writing and mailed or faxed to:

Office of Administrative Hearings

1020 S. Kansas Ave.

Topeka, KS 66612-1327

Fax: 785-296-4848

- The letter or fax must be received within 30 days of the date of the appeal decision.

Members have the right to benefits while a hearing is pending, and can request such benefits as part of their fair hearing request. All three MCOs will advise members of their right to a State Fair Hearing. Members do not have to finish their appeal with the MCO before requesting a State Fair Hearing.

Addressing specific additional elements required by CMS:

I. How individuals are informed of the Fair Hearing process during entrance to the waiver including how, when and by whom this information is provided to individuals.

For all KanCare MCOs: In addition to the education provided by the State, members receive information about the Fair Hearing process in the member handbook they receive at the time of enrollment. The member handbook is included in the welcome packet provided to each member. It will also be posted online at the MCOs' member web site. In addition, every notice of action includes detailed information about the Fair Hearing process, including timeframes, instructions on how to file, and who to contact for assistance. And, at any time a member can call the MCO to get information and assistance with the Fair Hearing process.

II. All instances when a notice must be made to an individual of an adverse action including: 1) choice of HCBS vs. institutional services, 2) choice of provider or service, and 3) denial, reduction, suspension or termination of service.

The state requires that all MCOs define an "action" pursuant to KanCare RFP Attachment C and 42 CFR §438.400. While the State determines, including through contracting entities, eligibility for HCBS waivers and is responsible for notifying an individual of an adverse action in the event that their application (choice of HCBS vs. institutional services) is denied, MCOs issue a notice of adverse action under the following circumstances:

- The denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service;
- The failure to provide services in a timely manner;
- The failure of an MCO to act within the timeframes provided in 42 CFR §438.408(b); and
- For a resident of a rural area with only one MCO, the denial of a Medicaid enrollee's request to exercise his or her right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network.

III. How notice of adverse action is made.

Amerigroup: Once the decision to deny a service is made, the Medical Director notifies the Health Care Management Services department of the denial by routing the authorization request to specified queues within Amerigroup's system of record (Facets). An Amerigroup Utilization Management nurse reviews the denial, makes any necessary updates to the authorization and routes it to the designated denial queue in Facets. The Case Specialist assigned to the queue will create the letter in Amerigroup's document repository system (Maccess) under the member's account and send to the Amerigroup Document Control Center (DCC) for mailing to both the member and the provider.

Sunflower: Sunflower will issue notice of adverse actions in writing. The notice of action letters utilized by Sunflower will have the prior written approval of KDHE before they are used. Written notification of adverse action may also be supplemented with telephonic and/or face-to-face notifications if necessary.

United: A Notice of Action is provided in writing to the member with a cc: to the provider.

IV. The entity responsible for issuing the notice

Amerigroup: Case Specialists in the Amerigroup Health Care Management Services Department are responsible for issuance of the notice (which includes the Amerigroup Medical Director's signature). These notices are sent from the Case Specialist to Amerigroup's Document Control Center for mailing.

Sunflower: Sunflower State Health Plan is responsible for issuing notifications to its enrolled members. Subcontracted entities who may be delegated appeal may also issue Notice of Action letters to members who are denied or received reduction of services that the delegated entity provides. All of the Sunflower's subcontracted entities will use the previously approved notice of action and grievance/appeal process letters that Sunflower uses.

United: UnitedHealthcare Community Plan will be issuing the notices.

V. The assistance (if any) that is provided to individuals in pursuing a Fair Hearing.

Amerigroup: The Amerigroup Quality Management Department includes Member Advocates that are dedicated to tasks such as helping members file grievances, appeals and Fair Hearings. If a member calls the Amerigroup Member Services line to request assistance with a Fair Hearing, our call center provides a transfer to the Member Advocate who assists the member.

Sunflower: Sunflower's Member Service Representative, Grievance and Appeals Coordinators and Care Managers will all be available to provide personal assistance to members needing support at any stage of the grievance process including Fair Hearing. They will provide information to members about their rights, how access the Fair Hearing process, provide assistance in completing any required documentation and provide all information relevant to the issue giving rise to the need for a Fair Hearing. In addition, Members will have access to communication assistance such as translation, TTY/TTD availability, interpreter services or alternative formats for member materials.

United: UnitedHealthcare has Member Advocates who can provide general assistance and a Plan Grievance Coordinator who is available to assist members with filing the request and who will prepare the files for submission to the State.

VI. Specify where notices of adverse action and the opportunity to request a Fair Hearing are kept.

Amerigroup: Template Notice of Adverse Action letters are housed in Amerigroup's electronic document repository system (Maccess). When individual letters are created, they are saved in the member's individual folder within this system. All these letters include notification of the opportunity to request a Fair Hearing.

Sunflower: Sunflower will maintain records of all notices of adverse action letters issued to members, with the required Fair Hear rights and process language, in our TruCare Medical Management application and in our Customer Relations Management (CRM) application used to track and report events in the grievance process.

United: Notice of Action letters are maintained in corporate letter archives. They are tied to the notification number in our CareOne Medical Management System. They are indexed by State, date of notice, member name. product (i.e. Medicaid) and notification number.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

- No. This Appendix does not apply**
 Yes. The State operates an additional dispute resolution process

- b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

All disputes (excluding those related to eligibility or across the board funding cuts implemented pursuant to the KDADS/CDDO Contract) shall follow the local dispute resolution process.

Pursuant to K.A.R. 30-64-32, the role of KDADS is to provide a summary review of the decision made by the CDDO Governing Board (or other designated board). KDADS reviews these decisions to ensure applicable policies, practices and procedures are followed at the local level. If they have not been correctly implemented, the review process provides CSP an opportunity to instruct the CDDO to make a corrective action. This process insures the appropriateness of local decisions to avoid having parties unnecessarily request a Fair Hearing. However, participants are informed that this process is not a pre-requisite for a fairing hearing or in any way prohibits the participant from pursuing a fair hearing.

If KDADS confirms the local decision, the party to the dispute will then be referred to the Office of Administrative Hearings (OAH).

A copy of K.A.R. 30-64-32 and a copy of the policy regarding K.A.R. 30-64-32 review is available to CMS upon request.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

- No. This Appendix does not apply**
 Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

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

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

Under the KanCare program, nearly all Medicaid services - including nearly all HCBS waiver services - will be provided through one of the three contracting managed care organizations. However, for those situations in which the participant is not a KanCare member, this grievance/complaint system applies. The Single State Medicaid Agency, Kansas Department of Health and Environment (KDHE), employs the fiscal agent to operate the consumer complaint and grievance system. (A description as to how KanCare members are informed that filing a grievance is not a prerequisite for a Fair Hearing is included at Appendix F.1.)

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

The Medical Assistance Customer Services Center (MACSC) at the fiscal agent is open to any complaint, concern, or grievance a consumer has against a Medicaid provider. The Consumer Assistance Unit staff logs and tracks all complaints, concerns, or grievances. If a provider has three complaints lodged against them, an investigation is initiated. KDADS has access to this information at any time.

The MACSC transfers grievances to the Quality Assurance Team (QAT) on the date received. QAT has 3 days to contact the grievant to acknowledge the grievance and 30 days to complete the research and resolution. IF more time is needed, QAT must request additional time from the State program manager.

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

As part of its role to educate consumers regarding their rights and responsibilities, CDDO's educate consumers regarding their due process rights including the complaint/grievance process and the fair hearing process. Consumers who are not part of the KanCare program are educated that lodging a complaint and/or grievance is not a pre-requisite or substitute for a Fair Hearing and is a separate activity from a Fair Hearing. This information may also be provided by the Waiver Program Manager.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

- a. Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. *Select one:*

- Yes. The State operates a Critical Event or Incident Reporting and Management Process** (*complete Items b through e*)
- No. This Appendix does not apply** (*do not complete Items b through e*)
If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

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

The state provides for the reporting and investigation of the following major and serious incidents Definitions of the types of critical events or incidents that must be reported:

Abuse – Any act or failure to act performed intentionally or recklessly that causes or is likely to cause harm to an adult including: 1) infliction of physical or mental injury; 2) any sexual act with an adult when the adult does not consent or when the other person knows or should know that the adult is incapable or resisting or declining consent to the sexual act due to mental deficiency or disease or due to fear of retribution or hardship; 3) unreasonable use of a physical restraint, isolation or medication that harms or is likely to ham an adult; 4)unreasonable use of a physical or chemical restraint, medication or isolation as punishment for convenience, in conflict with a physician’s orders or as a substitute for treatment, except where such conduct or physical restraint is in furtherance of the health and safety of the adult; 5)a threat or menacing conduct directed toward an adult that results or might reasonably be expected to result in fear or emotional or mental distress to an adult; 6)fiduciary abuse; or 7)omission or deprivation by a caretaker or another person of goods or services which are necessary to avoid physical or mental harm or illness. K.S.A 39-1430 (b)

Unreasonable use of a physical restraint, isolation or medication is defined as:

- Any use of the above that causes or is likely to cause harm to an adult.
- Any use of the above as punishment for convenience
- Any use of the above that is in conflict with a physician’s orders or as a substitute for treatment.
- Any use of the above, except where such conduct or physical restraint is in furtherance of the health and safety of

the adult.

DCF Division of Adult Protective Services is responsible for determination of unreasonable use of physical restraint, isolation or medication for each participant in accordance with the guidelines with the above listed for 'unreasonable use'.

Neglect – The failure or omission by one's self, caretaker or another person with a duty to supply or to provide goods or services which are reasonably necessary to ensure safety and well-being and to avoid physical or mental harm or illness. K.S.A 39-1430 (c)

Exploitation – Misappropriation of an adult's property or intentionally taking unfair advantage of an adult's physical or financial resources for another individual's personal financial advantage by the use of undue influence, coercion, harassment, duress, deception, false representation or false pretense by a caretaker or another person. K.S.A. 39-1430 (d)

Fiduciary Abuse – A situation in which any person who is the caretaker of, or who stands in a position of trust to, an adult, takes, secretes, or appropriates his/her money or property, to any use of purpose not in the due and lawful execution of such person's trust or benefit. K.S.A 39-1430 (e)

- Identification of the individuals/entities that must report critical events and incidents, and;

The Kansas statute (K.S.A. 39-1431) identifies mandated reporters required to report suspected abuse neglect, and exploitation or fiduciary abuse immediately to either the Department for Children and Families or Law Enforcement. According to K.S.A. 39-1431, mandated reporters include '(a) Any person who is licensed to practice any branch of the healing arts, a licensed psychologist, a licensed master level psychologist, a licensed clinical psychotherapist, the chief administrative officer of a medical care facility, a teacher, a licensed social worker, a licensed professional nurse, a licensed practical nurse, a licensed dentist, a licensed marriage and family therapist, a licensed clinical marriage and family therapist, licensed professional counselor, licensed clinical professional counselor, registered alcohol and drug abuse counselor, a law enforcement officer, a case manager, a rehabilitation counselor, a bank trust officer or any other officers of financial institutions, a legal representative, a governmental assistance provider, an owner or operator of a residential care facility, an independent living counselor and the chief administrative officer of a licensed home health agency, the chief administrative officer of an adult family home and the chief administrative officer of a provider of community services and affiliates thereof operated or funded by the department of social and rehabilitation services or licensed under K.S.A. 75-3307b and amendments thereto who has reasonable cause to believe that an adult is being or has been abused, neglected or exploited or is in need of protective services shall report, immediately from receipt of the information, such information or cause a report of such information to be made in any reasonable manner. An employee of a domestic violence center shall not be required to report information or cause a report of information to be made under this subsection.

- The timeframes within which critical events or incidents must be reported:

All reports of abuse, neglect, and exploitation must be reported to KDADS immediately.

- The method of reporting :

Reports shall be made to the Department of Aging and Disability Services during the normal working week days and hours of operation. Reporters can call the Kansas Protection Report Center in-state toll free at 1-800-922-5330. Telephone lines are staffed in the report center 24 hours a day, including holidays. In the event of an emergency, a report can be made to local law enforcement or 911.

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

- How training and/or information are furnished to participants or their informal caregivers concerning protections from abuse, neglect and exploitation, including how to notify the appropriate authorities, and;

- The entities responsible for providing training and/or information are specified:

To comply with the following regulations, any licensed provider is responsible for the delivery, oversight and management of programmatic systems to ensure any agent, person, parent, guardian and support network persons have appropriate contact information for DCF Adult Protective Services. KDADS-CSP ensures licensure compliance with the following regulations:

K.A.R. 30-63-28. Abuse; neglect; exploitation.

K.A.R. 30-63-22. Individual rights and responsibilities. Reporters can call the Kansas Protection Report Center in-

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

- The frequency of providing training and/or information is specified.

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

The AIR and review process is designed to facilitate ongoing quality improvement to ensure the health and safety of individuals receiving services. The MCO or KDADS utilize the AIR web application to report adverse incidents. Incidents are reported within 24 hours of the provider becoming aware of the occurrence of the adverse incident. Documents can be uploaded for review and tracking, and incident reports may be reviewed jointly by the designated KDADS quality manager and the MCO designee to determine whether further review or investigation is required. Adverse incidents to be reported include elopement, abuse, neglect and exploitation, serious injury, death, and misuse of medications.

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

- The entity that receives reports of each type of critical event or incident.

Kansas Department for Children and Families.

- The entity that is responsible for evaluating reports and how reports are evaluated.

Kansas Department for Children and Families (DCF) Intake Unit is responsible for receiving reports and determining if each report is screen in or out based on current policies identified in The Kansas Economic and Employment Support Manual [KEESM] for screening reports [12210]. If the report indicates criminal activity, local law enforcement is notified immediately.

The timeframes for conducting an investigation and completing an investigation.

For children, the State of Kansas requires reporting of any suspected Abuse, Neglect, Exploitation or Fiduciary Abuse of a child to DCF for review and follow-up. If the report alleges that a child is not in immediate, serious, physical danger, but the report alleges critical neglect or physical/sexual abuse, DCF must respond within 72 hours. If the report alleges that a child is not in immediate, serious, physical danger and the report does not allege physical or sexual abuse or neglect, DCF must respond within 20 working days. By policy, DCF is required to make a case finding in 25 working days from case assignment.

For adults, the State of Kansas requires reporting of any suspected Abuse, Neglect, Exploitation or Fiduciary Abuse of an adult to DCF for review and follow-up. K.S.A. 39-1433 establishes time frames for personal visits with involved adults and due dates for findings of DCF investigations. This statute identifies the following:

1. Twenty-four (24) clock hours if the involved adult's health or welfare is in imminent danger.
2. Three (3) working days if the involved adult has been abused but is not in imminent danger.
3. Five (5) working days if the adult has been neglected or exploited and there is no imminent danger.

The entity that is responsible for conducting investigations and how investigations are conducted.

Kansas Department for Children and Families (DCF).

DCF is responsible for contacting the involved adult, alleged perpetrator and all other collaterals to obtain relevant information for investigation purposes.

1. Interview the involved adult. If the involved adult has a legal guardian or conservator, contact the guardian and/or conservator.

2. Assess the risk of the involved adult.

3. The APS social worker should attempt to obtain a written release from involved adult or their guardian to receive/review relevant records maintained by others.

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

2540 Notice of Department Finding:

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

- The parents of the child who was alleged to have maltreated
- The alleged perpetrator
- Child, as applicable if the child lives separate from the family

- Contractor providing services to the family if the family is receiving services from a CFS contract
 - The director of the facility or the child placing agency of a foster home if abuse occurred in a facility or foster home
 - Kansas Department of Health and Environment if abuse occurred in a facility or a foster home
 - The Notice of Department Finding shall be mailed on the same day, or the next working day, as the case finding decision, the date on the Case Finding CFS-2011. The Notice of Department Finding shall be mailed on the same day, or the next working day, as the case finding decision, the date on the Case Finding CFS-2011.
- All case decisions/findings shall be staffed with the APS Supervisor/designee and a finding shall be made within (30) working days of receiving the report [K.S.A. 39-1433 (a)(3).]

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

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

- The state entity or entities responsible for overseeing the operation of the incident management system.

Kansas Department for Children and Families, Division of Adult Protective Services is responsible for overseeing the reporting of and response to all critical incidents and events. Adult Protective Services maintains a data base of all critical incidents/events and makes available the contents of the data base to the Kansas Department for Aging and Disability Services and the Kansas Department of Health and Environment, single state Medicaid agency, on an on-going basis.

- The methods for overseeing the operation of the incident management system, including how data are collected, compiled, and used to prevent re-occurrence.

Collaboration between the KDADS Field Staff and APS Social Worker includes meeting on a monthly basis to review trends and severity of Critical Events. KDADS Field Staff identify trends and severity with I/DD waiver providers to ensure adequate services and supports are in place.

The Performance Improvement Program Manager of KDADS, Community Supports & Programs, and the DCF Adult Protective Services Program Manager gather, trend and evaluate data from multiple sources that is reported to the KDADS CSP Director and the State Medicaid Agency.

This information will also be a monitoring, reporting and follow up element of the comprehensive KanCare quality improvement strategy, managed by an Interagency Monitoring Team to support overall quality improvement activities for the KanCare program.

- Frequency of oversight activities

KDADS conducts on-going, on-site, in-person reviews on a quarterly basis to educate and assess the consumer's knowledge and ability and freedom to prevent or report information about Abuse, Neglect, and Exploitation. If it is determined that there is suspected for Abuse, Neglect or Exploitation, the KDADS Field Staff report immediately. Any areas of vulnerability would be identified for additional training and assurance of education. KDADS Field Staff will be conducting a portion of these reviews with MCO staff, and over time the MCO staff will also be responsible for ensuring these issues are effectively in place for waiver participants, as part of the overall KanCare quality improvement strategy.

The state entity or entities responsible for overseeing the operation of the incident management system. DCF Division of Adult Protective Services is responsible for overseeing the reporting of and response to all critical incidents and events. Information and findings are reported to Kansas Department of Health and Environment through quarterly/annual reports during the Long Term Care Committee Meeting.

- The methods for overseeing the operation of the incident management system, including how data are collected, compiled, and used to prevent re-occurrence.
- Adult Protective Services maintains a data base of all critical incidents/events and makes available the contents of the data base to KDADS and KDHE.

Collaboration between the KDADS Field Staff and APS Social Worker occurs on a monthly basis to review trends and severity of Critical Events. KDADS Regional Field Staff identify trends and severity with providers to ensure adequate services and supports are in place for participants. The Performance Improvement Program Manager of KDADS and the DCF Adult Protective Services Program Manager gather, trend and evaluate data from multiple sources that is reported to the KDADS/CSP and the Kansas Department of Health and Environment.

- The frequency of oversight activities.

Oversight for compliance to assure the protection of adults, regulatory standards, and statute is conducted by the KDADS-CSP Regional Field Staff through on-going, on-site, and in-person review of the Person-Centered Support Plan. KDADS-CSP Regional Field Staff are responsible for addressing all confirmations with the service provider to ensure preventative action is taken for the protection of adults. Additionally, the Community Developmental Disability Organization monitors for compliance with regulatory standards and statute to assure the protection of adults through the Quality Assurance process.

Appendix G: Participant Safeguards

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

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

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

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

- The use of restraints or seclusion is permitted during the course of the delivery of waiver services.**

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

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

The State of Kansas does not allow for unreasonable use of physical or mechanical restraint.

39-1401 Abuse, neglect or exploitation of residents; definitions

(f)(3) unreasonable use of physical restraint, isolation or medication that harms or is likely to harm a resident;

(4) unreasonable use of a physical or chemical restraint, medication or isolation as punishment, for convenience, in conflict with a physician's orders or as a substitute for treatment except where such conduct or physical restraint is in furtherance of the health and safety of the resident or another resident; The use of alternative methods to avoid the use of restraints and seclusion.

KDADS Quality Management Specialists (QMS) use the quality survey tool, KLO2 (Kansas Lifestyle Outcomes 2), to review any restriction of a person's access to person, places or thing that protects the person's health & safety at risk, to monitor restraints & seclusion, & ensure compliance with regulated safeguards & standards. QMS conduct on-site & in-person (home or work) reviews of participant choice & independence, person rights & responsibility, health & safety, use of restrictions & appropriate safeguards. KDADS share data with the Kansas Department of Health & Environment (KDHE) at the Long-Term Care (LTC) meetings.

To avoid use of restraints & seclusion, QMS review policies, procedures, training & documentation for evidence that all potentially effective less restrictive alternatives were tried & proven ineffective. They conduct reviews to evidence of informed consent that includes information about positive behavior programming, environmental modifications & accommodations & the effective services available from the provider. It must also include a complete review of the risks, benefits & side effects prior to any restraints &/or seclusion including psychotropic medications, & that the required initial & ongoing assessment & responsive modifications are completed. QMS review of the following risks:

1. What is the person's history of decision-making?
2. What are the possible long & short term consequences associated with poor decision making? (What is the worst that could happen?)

3. What are the possible long & short term consequences of increased direction & control by staff or system?
4. What are the trade-offs of continuing the current situation?
5. Existence of safeguards to protect the person's rights.
6. Should more control & direction be provided? If yes, describe the proposed support which causes the least intrusion while adequately protecting the consumer.

Behavior Support Plans will be implemented, monitored by QMS and included in a person's Person-Centered Support Plan (PCSP). K.A.R. 30-63-23 requires the following:

1. If any restrictive intervention or psychotropic medication being used for or by the person, the person & support team have examined, determined & documented it to be the least restrictive intervention appropriate for this person.
2. If there is any restrictive intervention or psychotropic medication being used for or by the person, positive supports, accommodations & effective services have been considered, documented & are consistently present in the person's life.
3. If there is any restrictive intervention or psychotropic medication being used as a behavior support for or by the person, the behavioral issue being addressed is clearly defined, together with a description of how it's frequency and severity will be measured, as well as a description of how often the support will be reviewed & what criteria will be used for the reduction or elimination (only when appropriate) of the intervention or medication.
4. If there is a restrictive intervention or psychotropic medication being used as a behavior support for or by the person, staff have been trained in the appropriate use of the support, are accurately documenting the frequency & severity of the behavioral issue involved, & are consistently providing related positive behavioral supports.
5. If there is a restrictive intervention or psychotropic medication being used as a behavior support for or by the person, the provider is periodically reviewing & reporting to the person, support team & prescribing physician (when applicable), information about the frequency & severity of the behavioral issue involved, effectiveness of the intervention or medication being used, & any medication side effects.
6. There has been no utilization of law enforcement authorities to respond to behavioral support issues in the past year, absent a direct, significant & unabated threat to the physical safety of the person or others who cannot be promptly removed from danger unless specifically included in a plan meeting the requirements above.
7. There has been no utilization of physical restraint or seclusion to respond to behavioral support issues in the past year, absent a direct, significant & unabated threat to the physical safety of the person or others who cannot be promptly removed from danger, unless specifically included in a plan meeting the requirements above.

Methods for detecting the unauthorized use of restraints.

QMS provide oversight for compliance to assure protection against unauthorized use of restraint/seclusion & compliance with regulatory standards and statute is conducted by QMS. On-going review includes interviews with the individual, informal supports & paid staff support & review of person-centered support planning. Additionally, the Community Developmental Disability Organization monitors for compliance with regulatory standards and statute to assure protection from unauthorized restraint/seclusion.

The protocols that must be followed when restraints or seclusion are employed (including the circumstances when their use is permitted) & how their use is authorized.

AND;

The practices that must be employed to ensure the health & safety of individuals.

QMS are responsible for ensuring compliance with regulated safeguards through initial approval and on-going review of agency policies and procedures & regularly scheduled on-site in-person reviews with persons served by the agency. QMS Regional Field Staff monitor & assure compliance with, but not limited to:

K.A.R. 30-63-21. Person-Centered Support Planning

K.A.R. 30-63-22. Individual Rights & Responsibilities

K.A.R. 30-63-23. Medications; restrictive intervention; behavioral management committee

K.A.R. 30-63-24. Individual Health

K.A.R. 30-63-25. Staffing; abilities; staff health

K.A.R. 30-63-29. Records

Required documentation concerning the use of restraints or seclusion.

K.A.R. 30-63-23. Medications; restrictive interventions; behavioral management committee.

K.A.R. 30-63-23. Medications; restraints and/or seclusion; behavioral management committee requires QMS to monitor behavior management practices by reviewing PCSPs, interviewing staff, monitoring onsite, & reviewing documentation for evidence that services & supports are provided according to the PCSP. QMS review documentation for the following:

1. If any restrictive intervention or psychotropic medication being used for or by the person, the person & support team have examined, determined & documented it to be the least restrictive intervention appropriate for this person.
2. If there is any restrictive intervention or psychotropic medication being used for or by the person, positive supports, accommodations & effective services have been considered, documented & are consistently present in the person's life.
3. If there is any restrictive intervention or psychotropic medication being used for or by the person, the person & his/her guardian have received information about risks, benefits, side effects & alternatives, & have given voluntary, informed & documented consent for the use of the intervention or medication.
4. If there is any restrictive intervention or psychotropic medication being used as a behavior support for or by the person, the behavioral issue being addressed is clearly defined, together with a description of how it's frequency & severity will be measure, as well as a description of how often the support will be review & what criteria will be used for the reduction or elimination (only when appropriate) of the intervention or medication.
5. If there is a restrictive intervention or psychotropic medication being used as a behavior support for or by the person, staff have been trained in the appropriate use of the support, are accurately documenting the frequency & severity of the behavioral issue involved, & are consistently providing related positive behavioral supports.
6. If there is a restrictive intervention or psychotropic medication being used as a behavior support for or by the person, the provider is periodically reviewing & reporting to the person, support team & prescribing physician (when applicable), information about the frequency & severity of the behavioral issue involved, effectiveness of the intervention or medication being used, & any medication side effects.
8. If behavior management committee (meeting the membership criteria described in KAR 30-63-23[b] [3]) periodically reviews any use of restrictive interventions or psychotropic medication for or by the person to ensure the provisions of KAR 30-63-23 are met, & the provider is responsive to any findings or recommendation by that team.
10. There has been no utilization of physical restraint or seclusion or law enforcement authorities to respond to behavioral support issues in the past year, absent a direct, significant & unabated threat to the physical safety of the person or others who cannot be promptly removed from danger unless specifically included in a plan meeting the requirements above.

Education and training requirements that personnel who are involved in the administration of restraints or seclusion must meet.

Restraint/Seclusion

Training:

QMS review training records & interview to ensure compliance with mandatory training. Staff must be able to demonstrate understanding & implementation of the training (including the PCSP standards). MANDT training or other certified recognized behavior interventions is required if it is identified in the person's PCSP as an approved intervention. QMS review documentation & interview staff to demonstrate the following:

1. The person, his/her guardian & the support network have ongoing, individually-appropriate opportunities to learn about his/her individual rights & responsibilities, including at least annual training offered by the provider.
2. Staff are knowledgeable about & responsible to the person's health services & equipment needs.
3. Staff know how to access the Adult Protective Services contact number; & are knowledgeable about how to identify & report instances of suspected abuse, neglect or exploitation.
4. Staff trained in CPR & first aid are present whenever services are provided.
5. Staff have sufficient knowledge, competence & training to serve the person without oversight by another staff before working alone.

30-63-26. Staffing; abilities; staff health.

(a) A provider shall provide professional & direct service staff in numbers sufficient to meet the support & service needs of each person being served.

(b) Each employee shall be able to perform the employee's job duties before working without oversight

by another trained staff person.

(e) All staff or consultants representing themselves as professionals subject to national, state, or local licensing, certification or accreditation standards shall be in compliance & maintain compliance with those standards.

The KLO 2 (Kansas Lifestyle Outcomes 2) is the quality survey tool used to monitor safeguards & standards under the waiver. This process is described in Appendix H.

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

- The Kansas Department for Aging and Disability Services (KDADS-CSP) has primary responsibility for overseeing this issue, and works with the Kansas Department of Health and Environment (KDHE), as part of the comprehensive KanCare quality improvement strategy to monitor this service issue. Information and findings are reported to KDHE through quarterly/annual reports during the Long Term Care Committee Meeting.

- Methods for detecting unauthorized use, over use or inappropriate, ineffective use of restrictive interventions and ensuring that all applicable state requirements are followed.

KDADS conducts on-going, on-site, in-person reviews to educate and assess the consumer's knowledge, ability and freedom from the use of unauthorized restrictive interventions. If it is determined that there is suspected un-authorized use, the KDADS Field Staff report immediately to the Quality Program Manager and the appropriate abuse hotline. Immediate remediation would follow the reporting. Quality field staff will be responsible for ensuring these issues are effectively in place for waiver participants, as part of the overall KanCare quality improvement strategy.

- How data are analyzed to identify trends and patterns and support improvement strategies; and the methods for overseeing the operation of the incident management system including how data are collected, compiled, and used to prevent re-occurrence.

KDADS Field Staff conduct on-going, record review and on-site, in-person interviews with the consumer and his/her informal supports and paid staff supports to ensure there is no use of unauthorized restrictive interventions, restraint and seclusion. KDADS Field staff review planning for each individual to ensure appropriate supports and services are in place to eliminate the need for restrictive intervention.

The following Performance Improvement Analysis Process occurs on an annual basis.

1. Data Aggregation is completed by the data analysis staff.

2. Performance Improvement Analysis Process including:

- a. Performance Improvement Team including the Program Manager, Quality and TCM program Manager, data analysis staff and QMS staff reviews the data for trends and determines the necessity of changes to the tool, training or program might be necessary.

3. Performance Improvement Waiver Report provided to Kansas Health Policy Authority via the KHPA Long Term Care Committee, for review by the State Medicaid Agency (SSMA).

- The methods for overseeing the operation of the incident management system including how data are collected, compiled, and used to prevent re-occurrence.

Oversight for compliance to assure the protection of adults, regulatory standards, and statute is conducted by KDADS-CSP Field Staff (QMS) through on-going, on-site record review, observation, interviews of individuals served, guardians if applicable, and staff, review of compliance of the individual's Person-Centered Support Plan. KDADS-CSP (QMS) Field Staff are responsible for addressing all unauthorized restraint and seclusion with the service provider to ensure preventative action is taken for the protection of adults. Additionally, the Community Developmental Disability Organization monitors for compliance with regulatory standards and statute to assure the protection of adults through their Quality Assurance process.

Data gathered by KDADS-CSP Field Staff during the Quality Review Process is provided quarterly to the KDADS-CSP Performance Improvement team chaired by the Quality Program Manager, for evaluation and trending to identify areas for improvement. Upon completion of identified areas of improvement this information is compiled into an executive report (quarterly and annually) which is submitted to the Performance Improvement Executive Committee Chaired by the Assistant Director KDADS-CSP, staffed by HCBS Program Managers, QA Program Manager. The Performance Improvement Committee generates corrective action planning and improvement planning which is

submitted to the Director of KDADS-CSP, the Medicaid Operating Agency, for review and approval or denial and sent to the Kansas Health Policy Authority (KPHA) via the KPHA Long Term Care Committee for review by the State Medicaid Agency (SSMA). The approval or denial from the Director of KDADS-CSP would be returned to the Performance Improvement team for corrective action or planning for implementation of improvement.

- The frequency of oversight: Continuous and ongoing.

Appendix G: Participant Safeguards

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

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

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

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

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

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

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

The use of alternative methods to avoid the use of restrictive interventions.

KDADS-CSP Regional Field Staff are responsible for ensuring compliance with regulated safeguards through initial approval and on-going review of agency policies and procedures and regularly scheduled on-site in-person reviews with persons served by the agency. For each type of restrictive intervention, including physical and chemical, the following alternative methods are used to avoid use of the above stated. For any restriction of an individual's access to person, places or thing that put the individual's health and safety at risk a Risk Assessment addressing the following must be in place. Review of this information is included in the KLO2 process and through interview and on-site monitoring by field staff.

1. What is the person's history of decision-making?
2. What are the possible long and short term consequences associated with poor decision making? (What is the worst that could happen?)
3. What are the possible long and short term consequences of increased direction and control by staff or system?
4. What are the trade-offs of continuing the current situation?
5. Existence of safeguards to protect the person's rights.
6. Should more control and direction be provided? If yes, describe the proposed support which causes the least intrusion while adequately protecting the consumer.

Behavior Support Plans will be implemented in accordance with K.A.R. 30-63-23 Medications; restrictive interventions; behavioral management committee.

A Behavior Support Plan is monitored in accordance with the following KLO2 standards and is included in the individual's Person-Centered Support Plan.

1. If any restrictive intervention or psychotropic medication being used for or by the person, the person and support team have examined, determined and documented it to be the least restrictive intervention appropriate for this person.
2. If there is any restrictive intervention or psychotropic medication being used for or by the person, positive supports, accommodations and effective services have been considered, documented and are consistently present in the person's life.
3. If there is any restrictive intervention or psychotropic medication being used as a behavior support for or by the person, the behavioral issue being addressed is clearly defined, together with a description of how it's frequency and severity will be measure, as well as a description of how often the support will be review and what criteria will be used for the reduction or elimination (only when appropriate) of the

intervention or medication.

4. If there is a restrictive intervention or psychotropic medication being used as a behavior support for or by the person, staff have been trained in the appropriate use of the support, are accurately documenting the frequency and severity of the behavioral issue involved, and are consistently providing related positive behavioral supports.

5. If there is a restrictive intervention or psychotropic medication being used as a behavior support for or by the person, the provider is periodically reviewing and reporting to the person, support team and prescribing physician (when applicable), information about the frequency and severity of the behavioral issue involved, effectiveness of the intervention or medication being used, and any medication side effects.

6. There has been no utilization of laws enforcement authorities to respond to behavioral support issues in the past year, absent a direct, significant and unabated threat to the physical safety of the person or others who cannot be promptly removed from danger unless specifically included in a plan meeting the requirements above.

7. There has been no utilization of physical restraint or seclusion to respond to behavioral support issues in the past year, absent a direct, significant and unabated threat to the physical safety of the person or others who cannot be promptly removed from danger, unless specifically included in a plan meeting the requirements above.

- Methods for detecting the unauthorized use of restrictive intervention.

Oversight for compliance to assure protection against unauthorized use of restrictive interventions and compliance with regulatory standards and statute is conducted by the KDADS-CSP Regional Field Staff. On-going review includes interviews with the individual, informal supports and paid staff support and review of person-centered support planning. Additionally, the Community Developmental Disability Organization monitors for compliance with regulatory standards and statute to assure protection from unauthorized restrictive intervention.

- Documentation Required:

K.A.R. 30-63-23. Medications; restrictive interventions; behavioral management committee.

(1) Safeguards, which shall include initial and ongoing assessment and responsive modifications that may be needed to ensure and document the following, in consultation with the person, the person's guardian, and the person's support network:

(A) All other potentially effective, less restrictive alternatives have been tried and shown ineffective, or a determination using best professional clinical practice indicates that less restrictive alternatives would not likely be effective;

(B) positive behavior programming, environmental modifications and accommodations, and effective services from the provider are present in the person's life;

(C) voluntary, informed consent has been obtained from the person or the person's guardian if one has been appointed, after a review of the risks, benefits, and side effects, as to the use of any restrictive interventions or medications; and

(D) medications are administered only as prescribed, and no "PRN" (provided as needed) medications are utilized without both the express consent of the person or the person's guardian if one has been appointed, and per usage approval from the prescribing physician or another health care professional designated by the person or the person's guardian if one has been appointed.

The above must be documented in each individual's Person-Centered Support Plan in accordance with K.A.R. 30-63-21. Person-centered support planning; implementation.

Required documentation:

The field staff monitors for documentation of the following standards in the Person-Centered Support Plan and evidence services and supports are provided in accordance with the Person-Centered Support Plan through interview and on-site monitoring during the KLO2 Quality Review process.

1. If any restrictive intervention or psychotropic medication being used for or by the person, the person and support team have examined, determined and documented it to be the least restrictive intervention appropriate for this person.

2. If there is any restrictive intervention or psychotropic medication being used for or by the person, positive supports, accommodations and effective services have been considered, documented and are consistently present in the person's life.

3. If there is any restrictive intervention or psychotropic medication being used for or by the person, the person and his/her guardian have received information about risks, benefits, side effects and alternatives, and have given voluntary, informed and documented consent for the use of the intervention or

medication.

4. If there is any restrictive intervention or psychotropic medication being used as a behavior support for or by the person, the behavioral issue being addressed is clearly defined, together with a description of how it's frequency and severity will be measure, as well as a description of how often the support will be review and what criteria will be used for the reduction or elimination (only when appropriate) of the intervention or medication.

5. If there is a restrictive intervention or psychotropic medication being used as a behavior support for or by the person, staff have been trained in the appropriate use of the support, are accurately documenting the frequency and severity of the behavioral issue involved, and are consistently providing related positive behavioral supports.

6. If there is a restrictive intervention or psychotropic medication being used as a behavior support for or by the person, the provider is periodically reviewing and reporting to the person, support team and prescribing physician (when applicable), information about the frequency and severity of the behavioral issue involved, effectiveness of the intervention or medication being used, and any medication side effects.

8. A behavior management committee (meeting the membership criteria described in KAR 30-63-23[b] [3]) periodically reviews any use of restrictive interventions or psychotropic medication for or by the person to ensure the provisions of KAR 30-63-23 are met, and the provider is responsive to any findings or recommendation by that team.

10. There has been no utilization of laws enforcement authorities to respond to behavioral support issues in the past year, absent a direct, significant and unabated threat to the physical safety of the person or others who cannot be promptly removed from danger unless specifically included in a plan meeting the requirements above.

11. There has been no utilization of physical restraint or seclusion to respond to behavioral support issues in the past year, absent a direct, significant and unabated threat to the physical safety of the person or others who cannot be promptly removed from danger, unless specifically included in a plan meeting the requirements above.

• Training Required:

Restrictive Intervention

Training:

The field staff monitors for staff training of the following standards in the Person-Centered Support Plan and evidence services and supports are provided in accordance with the Person-Centered Support Plan through interview and on-site monitoring during the KLO2 Quality Review process.

1. The person, his/her guardian and the support network have ongoing, individually-appropriate opportunities to learn about his/her individual rights and responsibilities, including at least annual training offered by the provider.

2. Staff are knowledgeable about and responsible to the person's health services and equipment needs.

3. Staff know how to access the Adult Protective Services contact number; and are knowledgeable about how to identify and report instances of suspected abuse, neglect or exploitation.

4. Staff trained in CPR and first aid are present whenever services are provided.

5. Staff have sufficient knowledge, competence and training to serve the person without oversight by another staff before working alone.

6. If there is a restrictive intervention or psychotropic medication being used as a behavior support for or by the person, staff have been trained in the appropriate use of the support, are accurately documenting the frequency and severity of the behavioral issue involved, and are consistently providing related positive behavioral supports.

30-63-26. Staffing; abilities; staff health.

(a) A provider shall provide professional and direct service staff in numbers sufficient to meet the support and service needs of each person being served.

(b) Each employee shall be able to perform the employee's job duties before working without oversight by another trained staff person.

(e) All staff or consultants representing themselves as professionals subject to national, state, or local licensing, certification or accreditation standards shall be in compliance and maintain compliance with those standards.

All staff are required to have training and the QMS staff reviews training records onsite and conducts interviews with staff to determine training has been completed and each individual can demonstrate understanding and implementation of the training. MANDT or other certified recognized behavior intervention training is required, if an individual has it in their plan of an approvable intervention.

Restrictions are person specific and are what the individual and/or their team deems necessary, after other less-restrictive measures have been tried, to keep the individual safe or others around them safe. There is not a "listing" of what is permissible, however, a risk assessment is first necessary to determine the necessity of the restriction, a Behavior Management Plan (BMP) must be developed to provide a plan and oversight and then the plan must be reviewed by a Human Rights Committee (HRC) or also known as a Behavior Management Committee (BMC) to review the planned restriction. Some examples of restrictions may be locking food up for those with an eating disorder, or keeping sharps locked up, or one-on-one staff to be available to help de-escalate a situation or prevent aggressive behaviors to another individual, or self-harm

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

- The state agency (or agencies) responsible for overseeing the use of restrictive procedures and ensuring that the state's safeguards are followed.

Kansas Department for Aging and Disability Services (KDADS-CSP). Information and findings are reported to KDHE (Kansas Department of Health and Environment) through quarterly/annual reports during the Long Term Care Committee Meeting.

- Methods for detecting unauthorized use, over use or inappropriate, ineffective use of restrictive procedures and ensuring that all applicable state requirements are followed.

KDADS-CSP conduct on-going, on-site, in-person reviews to educate and assess the consumer's knowledge, ability and freedom from inappropriate use of restrictive procedures. If it is determined that there is suspected un-authorized use, the KDADS-CSP Field Staff request immediate corrective action by the agency to ensure appropriate supports and services for the individual to eliminate the need for restrictive intervention. Any areas of vulnerability would be identified with the service provider for additional training and assurance of non-aversive methods.

- How data are analyzed to identify trends and patterns and support improvement strategies.

KDADS-CSP maintains data of restrictive intervention use and makes available the contents of the data to the Kansas Department of Health and Environment.

Statewide/Regional/Provider data is compiled, trended, reviewed, and disseminated to providers through the Performance Improvement Analysis Process. Each provider receives annual data trending which identifies provider specific performance levels related to statewide performance standards and statewide averages. Corrective Action Plan requests and/or technical assistance to remediate negative trending are included in annual provider reports where negative trending is evidenced. The state has a system intervention process in place that allows participants across the state 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. This systems integration process involves establishing relationships between parties that result in common goals, mission, and philosophy.

The following Performance Improvement Analysis Process occurs on an annual basis.

1. Performance Improvement Data Aggregation (Central Office Performance Improvement Program Manager)
2. Performance Improvement Analysis Process including:
 - a. Community Choice Reflection Team (100% consumer members) review of statewide data versus local provider trends)
 - b. Performance Improvement Review Committee (Central Office PI Program Manager and Regional KDADS field staff)
 - c. Performance Improvement Executive Review Committee (Central Office Assistant Director, Performance Improvement Program Manager and waiver program managers.)
3. Performance Improvement Waiver Report provided to the Kansas Department of Health and Environment via the KDHE Long Term Care Committee, for review by the State Medicaid Agency (SSMA).

- The methods for overseeing the operation of the incident management system including how data are collected, compiled, and used to prevent re-occurrence.

Oversight for compliance to assure the protection of adults, regulatory standards, and statute is conducted by the KDADS-CSP Regional Field Staff through on-going, on-site, and in-person review of

the Person-Centered Support Plan. KDADS-CSP Regional Field Staff are responsible for addressing all unauthorized restrictive interventions with the service provider to ensure preventative action is taken for the protection of adults. Additionally, the Community Developmental Disability Organization monitors for compliance with regulatory standards and statute to assure the protection of adults through the Quality Assurance process.

Data gathered by KDADS-CSP Regional Staff during the Quality Survey Process is provided quarterly to the KDADS-CSP Performance Improvement Review Committee [Chaired by the Performance Improvement Program Manager / staffed by PI Staff statewide] for evaluation and trending to identify areas for improvement. Upon completion of identified areas of improvement this information is compiled into an executive report (quarterly and annually) which is submitted to the Performance Improvement Executive Committee [Chaired by the Assistant Director KDADS-CSP / staffed by Waiver Program Managers, QA Program Manager and PI Program Manager]. The Performance Improvement Executive Committee generates corrective action planning and improvement planning which is submitted to the Director of KDADS-CSP, the Medicaid Operating Agency, for review and approval/denial and sent to the Kansas Department of Health and Environment (KDHE) via the KDHE Long Term Care Committee for review by the State Medicaid Agency (SSMA). The approval/denial from the Director of KDADS-CSP would be returned to the Performance Improvement Executive Committee for corrective action or planning for implementation of improvement.

- The frequency of oversight.
KDADS-CSP Regional Field Staff conduct on-going, on-site, in-person reviews to educate and assess the consumer's knowledge and ability and freedom from the use of restrictive procedures.

Appendix G: Participant Safeguards

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

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

a. Applicability. Select one:

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

b. Medication Management and Follow-Up

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

- The entity or entities responsible for ongoing monitoring of participant medication regimens.
Kansas Department for Aging and Disabilities Services Community Supports and Programs (KDADS-CSP) Regional Field Staff.

- The scope of monitoring.

Each licensed entity shall maintain records in accordance with K.A.R. 30-63-29; Records.

(a) A provider shall maintain records for each person served. These records shall include the following:

(4) a health profile, which shall be reviewed for accuracy by a licensed medical practitioner at least every two years, and shall include the following:

(A) notations regarding the person's health status;

(B) any medications the person takes; and

(C) any other special medical or health considerations which might exist for that person.

Monitoring is designed to specifically focus on the use of psychotropic medication. The following regulated safeguards are monitored for compliance by the licensed provider.

K.A.R. 30-63-23. Medications; behavioral management committee.

- Methods for conducting monitoring.

KDADS/CSP Regional Field Staff are responsible for ensuring compliance with regulated safeguards through initial approval and on-going review of agency policies and procedures and regularly scheduled on-site in-person reviews with persons served by the agency. KDADS/CSP Regional Field Staff monitor and assure compliance with, but not limited to:

K.A.R. 30-63-21. Person-Centered Support Planning

K.A.R. 30-63-22. Individual Rights and Responsibilities

K.A.R. 30-63-23. Medications; restrictive intervention; behavioral management committee

K.A.R. 30-63-24. Individual Health

K.A.R. 30-63-25. Staffing; abilities; staff health

K.A.R. 30-63-29. Records

Additionally, the Community Developmental Disability Organization monitors for the above areas of compliance through the Quality Assurance Process.

- Frequency of monitoring.

Each licensed entity is responsible for developing and monitoring participant medication regimens, the methods for conducting monitoring and the frequency of monitoring. Additionally, each licensed entity must assure the state of compliance with the Nurse Practice Act [K.S.A. 65-1124] for providing auxiliary patient care services under the direction of a person licensed to practice medicine or the supervision of a registered professional nurse or a licensed practical nurse. KDADS monitors for licensing compliance with K.A.R. 30-63-25. Individual health:

(b) Non-licensed personnel shall administer medications and perform nursing tasks or activities in conformance with the provisions of K.S.A. 65-1124, and amendments thereto.

- How monitoring has been designed to detect potentially harmful practices and follow-up to address such practices.

Medication regimens are developed by qualified medical personnel according to the individual's specific medical needs as authorized by licensed medical professionals. Training requirements for personnel providing medication administration and restrictive interventions will comply with agency policies and procedures approved by and monitored by KDADS/CSP Regional Field Staff.

Medication

Training:

The field staff monitors for staff training of the following standards in the Person-Centered Support Plan and evidence services and supports are provided in accordance with the Person-Centered Support Plan through interview and on-site monitoring during the KLO2 Quality Review process.

1. The person, his/her guardian and the support network have ongoing, individually-appropriate opportunities to learn about his/her individual rights and responsibilities, including at least annual training offered by the provider.
2. Staff are knowledgeable about and responsible to the person's health services and equipment needs.
3. Staff are aware of the medications used by the person; are knowledgeable of the purpose and potential side effects of the medications; and know how to respond effectively if negative side effects occur.
4. Any administration of medication or other nursing tasks or activities are performed only by staff to whom a nurse has trained and delegated the duty and under the nurse's supervision.
5. Staff trained in CPR and first aid are 0.
present whenever services are provided.
6. Staff have sufficient knowledge, competence and training to serve the person without oversight by another staff before working alone.
7. If there is a restrictive intervention or psychotropic medication being used as a behavior support for or by the person, staff have been trained in the appropriate use of the support, are accurately documenting the frequency and severity of the behavioral issue involved, and are consistently providing related positive behavioral supports.

- For waivers that serve individuals with cognitive impairments or mental disorders, how second-line monitoring is conducted concerning the use of behavior modifying medications.

Second line monitoring with regard to use of behavior modifying medications will be reviewed by a behavior management committee established by the provider which meets the criteria established in K.A.R. 30-63-23. Oversight of compliance with the above regulatory standards and statute is conducted by the KDADS/CSP Regional Field Staff through on-going, on-site, and in-person review of Person-Centered Support Planning and compliance with regulatory standards. Additionally, the Community Developmental Disability Organization monitors these areas of compliance through the Quality Assurance Process.

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

- The state agency (or agencies) responsible for oversight.

Kansas Department for Aging and Disability Services - Community Supports and Programs (KDADS-CSP) is responsible for oversight and follow-up of appropriate medication management for participants. Information and findings are reported to KDHE (Kansas Department of Health and Environment) through quarterly/annual reports during the Long Term Care Committee Meeting.

- How state monitoring is performed and how frequently.

Statewide/Regional/Provider data is compiled, trended, reviewed, and disseminated to providers through the Performance Improvement Analysis Process. Each provider receives annual data trending which identifies provider specific performance levels related to statewide performance standards and statewide averages. Corrective Action Plan requests and/or technical assistance to remediate negative trending are included in annual provider reports where negative trending is evidenced. The state has a system intervention process in place that allows participants across the state 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. This systems integration process involves establishing relationships between parties that result in common goals, mission, and philosophy.

Data gathered by KDADS-CSP Regional Staff during the Quality Survey Process is provided quarterly to the KDADS-CSP Performance Improvement Review Committee [Chaired by the Performance Improvement Program Manager / staffed by PI Staff statewide] for evaluation and trending to identify areas for improvement. Upon completion of identified areas of improvement this information is compiled into an executive report (quarterly and annually) which is submitted to the Performance Improvement Executive Committee [Chaired by the Assistant Director KDADS-CSP and staffed by Waiver Program Managers, QA Program Manager and PI Program Manager]. The Performance Improvement Executive Committee generates corrective action planning and improvement planning which is submitted to the Director of KDADS/CSP, the Medicaid Operating Agency, for review and approval/denial and sent to the Kansas Department of Health and Environment (KDHE) via the KDHE Long Term Care Committee for review by the State Medicaid Agency (SSMA). The approval/denial from the Director of KDADS-CSP would be returned to the Performance Improvement Executive Committee for corrective action or planning for implementation of improvement.

- How the state monitoring program gathers information concerning potentially harmful practices and employs such information to improve quality.

Oversight of compliance with regulatory standards and statute is conducted by the KDADS-CSP Regional Field Staff through on-going, on-site, and in-person review of Person-Centered Support Planning and compliance with regulatory standards. Specifically, KDADS-CSP Regional Field Staff monitor for the use of 'out-dated' psychotropic medication. Identified issues of non-compliance are directed to the appropriate agency by KDADS/CSP Regional Field Staff for follow-up and improvement.

The KDADS-CSP Regional Field Staff monitor for compliance with the following regulations to ensure participant medications are managed appropriately and for identification and remediation of potentially harmful practices. These regulations include, but are not limited to:

K.A.R. 30-63-21. Person-Centered Support Planning

K.A.R. 30-63-22. Individual Rights and Responsibilities

K.A.R. 30-63-23. Medications; restrictive interventions; behavioral management committee

K.A.R. 30-63-24. Individual Health

K.A.R. 30-63-25. Staffing; abilities; staff health

K.A.R. 30-63-29. Records

Additionally, the Community Developmental Disability Organization monitors the above areas of compliance through the Quality Assurance Process.

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

executive report (quarterly and annually) which is submitted to the Performance Improvement Executive Committee [Chaired by the Assistant Director KDADS-CSP staffed by Waiver Program Managers, QA Program Manager and PI Program Manager]. The Performance Improvement Executive Committee generates corrective action planning and improvement planning which is submitted to the Director of KDADS-CSP of Operating Agency for review and approval/denial. KDADS Program Manager and Assistant Director present quality reports(quarterly and annually) to the Kansas Department of Health and Environment (KDHE) via the KDHE Long Term Care Committee for review by the State Medicaid Agency (SSMA). Additionally, KDADS-CSP is in attendance at the monthly Long Term Care Committee meeting to provide updates with regard to waiver quality processes and HCBS issues as they arise.

Whenever a quality reviewer encounters an HCBS-I/DD participant with an identifiable health and/or welfare issue, including medication management issues, the reviewer either 1) makes a referral to APS if, in the reviewer's and his or her supervisor's opinion, the issue involves abuse, neglect, or exploitation of the participant, or 2) reports concerns to the MCO or contact person at the managed care entity if the situation is of concern but does not warrant, in the reviewer's opinion, an APS referral. The same standard is used in reporting concerns of potential abuse, neglect, and exploitation to KDADS LCE.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

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

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

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

The state's policies concerning the administration of medication to individuals who are unable to self-administer and the responsibilities of providers for overseeing self-administration.

Each licensed entity is responsible for developing and monitoring participant medication regimens, the methods for conducting monitoring and the frequency of monitoring. Additionally, each licensed entity must assure the state of compliance with the Nurse Practice Act [K.S.A. 65-1124] for providing auxiliary patient care services under the direction of a person licensed to practice medicine or the supervision of a registered professional nurse or a licensed practical nurse. KDADS monitors for licensing compliance with K.A.R. 30-63-25. Individual health:

- (a) A provider shall assist each person served, as necessary, in obtaining the medical and dental services to which the person has access and that may be required to meet the person's specific health care needs, including the following:
- (b) Non-licensed personnel shall administer medications and perform nursing tasks or activities in conformance with the provisions of K.S.A. 65-1124, and amendments thereto.
- (c) A provider shall train staff who shall be responsible to implement the service provider's written policies and procedures for carrying out medication administration, including the following:
- (1) Self-administration by any person;
 - (2) medication checks and reviews;
 - (3) emergency medical procedures; and
 - (4) any other health care task.

Medication regimens are developed by qualified medical personnel according to the individual's specific medical needs as authorized by licensed medical professionals. Training requirements for personnel providing medication administration and restrictive interventions will comply with agency policies and procedures approved by and monitored by KDADS/CSP Regional Field Staff.

- If applicable, the training/education that non-medical waiver providers must have in order to administer

medications to participants who cannot self-administer and the extent of the oversight of these personnel by licensed medical professionals.

Each licensed entity is responsible for developing and monitoring participant medication regimens, the methods for conducting monitoring and the frequency of monitoring. Additionally, each licensed entity must assure the state of compliance with the Nurse Practice Act [K.S.A. 65-1124] for providing auxiliary patient care services under the direction of a person licensed to practice medicine or the supervision of a registered professional nurse or a licensed practical nurse. KDADS monitors for licensing compliance with K.A.R. 30-63-25. Individual health:

(a) A provider shall assist each person served, as necessary, in obtaining the medical and dental services to which the person has access and that may be required to meet the person's specific health care needs, including the following:

(b) Non-licensed personnel shall administer medications and perform nursing tasks or activities in conformance with the provisions of K.S.A. 65-1124, and amendments thereto.

(c) A provider shall train staff who shall be responsible to implement the service provider's written policies and procedures for carrying out medication administration, including the following:

- (1) Self-administration by any person;
- (2) medication checks and reviews;
- (3) emergency medical procedures; and
- (4) any other health care task.

Medication regimens are developed by qualified medical personnel according to the individual's specific medical needs as authorized by licensed medical professionals. Training requirements for personnel providing medication administration and restrictive interventions will comply with agency policies and procedures approved by and monitored by KDADS/CSP Regional Field Staff.

Medication

Training:

The field staff monitors for staff training of the following standards in the Person-Centered Support Plan and evidence services and supports are provided in accordance with the Person-Centered Support Plan through interview and on-site monitoring during the KLO2 Quality Review process.

1. The person, his/her guardian and the support network have ongoing, individually-appropriate opportunities to learn about his/her individual rights and responsibilities, including at least annual training offered by the provider.
2. Staff are knowledgeable about and responsible to the person's health services and equipment needs.
3. Staff are aware of the medications used by the person; are knowledgeable of the purpose and potential side effects of the medications; and know how to respond effectively if negative side effects occur.
4. Any administration of medication or other nursing tasks or activities are performed only by staff to whom a nurse has trained and delegated the duty and under the nurse's supervision.
5. Staff trained in CPR and first aid are present whenever services are provided.
6. Staff have sufficient knowledge, competence and training to serve the person without oversight by another staff before working alone.
7. If there is a restrictive intervention or psychotropic medication being used as a behavior support for or by the person, staff have been trained in the appropriate use of the support, are accurately documenting the frequency and severity of the behavioral issue involved, and are consistently providing related positive behavioral supports.

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

- Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**

Complete the following three items:

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

Providers must report all medication errors that result in emergency medical treatment or incident. Information and findings are reported to KDHE (Kansas Department of Health and Environment) through quarterly/annual reports during the Long Term Care Committee Meeting.

The State has designed a critical incident reporting system called Adverse Incident Reporting System (AIR). KDADS quality management team will be responsible for the administration and oversight of this reporting process.

The critical incident reporting and review process is designed to facilitate ongoing quality improvement to ensure the health and safety of individuals receiving services by agencies licensed and/or funded by KDADS. It is intended to provide information to improve policies, procedures, and practices.

Each medication error incident shall be reported using the AIR system within 24 hours of the provider becoming aware of the occurrence of the critical incident. Forms are completed and submitted through a secure web-based connection to KDADS.

Upon receipt at KDADS, email notification is sent to the appropriate program staff as determined by the provider type. The individual MCO identified on the form is notified at the same time. Reporting parameters, including timeliness and content will be determined by contractual requirements.

All reportable critical incidents shall be documented and analyzed as part of the provider's quality assurance and improvement program. Incident reports are reviewed jointly by the KDADS quality team and the MCO designee to determine whether further review or investigation is needed. Reviews or investigations shall be completed following relevant KDADS policies and procedures.

If it is determined that an investigation is warranted (including those events designated in article 63 of the DRA, 30-63-23, the incident will be investigated by KDADS quality team for confirmation of incidence and work with the MCOs for provider remediation. As a result, the provider may be asked to submit a written corrective action plan. If the corrective action plan does not demonstrate compliance with provider standards, the program's license may be suspended, pending satisfactory resolution of the critical incident. If the critical incident is not resolved within a specified time line from the date of the initial critical incident, the provider's license may be revoked.

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

Providers must report all medication errors that result in emergency medical treatment or incident. Information and findings are reported to KDHE (Kansas Department of Health and Environment) through quarterly/annual reports during the Long Term Care Committee Meeting.

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

Licensed providers are responsible for reporting any medication errors resulting in injury to the participant which require emergency medical services, hospitalization or death to DCF Adult Protective Services and KDADS/CSP.

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

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

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

- The state agency (or agencies) responsible for the on-going monitoring of waiver provider agencies' performance in administering participant medications. The Kansas Department for Aging and Disability Services-Community Supports and Programs is responsible for oversight and follow-up of waiver provider agencies' performance in administering participant medications.

- When oversight is not conducted by the Medicaid agency or the operating agency (if applicable), the process to communicate information and findings to the Medicaid agency or the operating agency. Information and findings are reported to KDHE (Kansas Department of Health and Environment) during the Long Term Care Committee Meeting.

Data gathered by KDADS-CSP Regional Staff during the Quality Survey Process is provided quarterly to the

KDADS/CSP Performance Improvement Review Committee [Chaired by the Performance Improvement Program Manager / staffed by PI Staff statewide] for evaluation and trending to identify areas for improvement. Upon completion of identified areas of improvement this information is compiled into an executive report (quarterly and annually) which is submitted to the Performance Improvement Executive Committee [Chaired by the Assistant Director of KDADS/CSP staffed by Waiver Program Managers, QA Program Manager and PI Program Manager]. The Performance Improvement Executive Committee generates corrective action planning and improvement planning which is submitted to the Director of KDADS/CSP, the Medicaid Operating Agency, for review and approval/denial and sent to the Kansas Department of Health and Environment (KDHE) via the KDHE Long Term Care Committee for review by the State Medicaid Agency (SSMA). The approval/denial from the Director of KDADS/CSP would be returned to the Performance Improvement Executive Committee for corrective action or planning for implementation of improvement. Additionally, KDADS-CSP is in attendance at the monthly Long Term Care Committee meeting to provide updates with regard to waiver quality processes and HCBS issues as they arise.

- Monitoring methods that include the identification of problems in provider performance and support follow-up remediation actions and quality improvement activities.

Statewide/Regional/Provider data is compiled, trended, reviewed, and disseminated to providers through the Performance Improvement Analysis Process. Each provider receives annual data trending which identifies provider specific performance levels related to statewide performance standards and statewide averages. Corrective Action Plan requests and/or technical assistance to remediate negative trending are included in annual provider reports where negative trending is evidenced. The state has a system intervention process in place that allows participants across the state 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. This systems integration process involves establishing relationships between parties that result in common goals, mission, and philosophy.

The following Performance Improvement Analysis Process occurs on an annual basis.

1. Performance Improvement Data Aggregation (Central Office Performance Improvement Program Manager)
2. Performance Improvement Analysis Process including:
 - a. Community Choice Reflection Team (100% consumer members) review of statewide data versus local provider trends)
 - b. Performance Improvement Review Committee (Central Office PI Program Manager and Regional KDADS field staff)
 - c. Performance Improvement Executive Review Committee (Central Office Assistant Director, Performance Improvement Program Manager and waiver program managers.)
3. Performance Improvement Waiver Report provided to Kansas Department of Health and Environment via the KDHE Long Term Care Committee, for review by the State Medicaid Agency (SSMA).

- How data are acquired to identify trends and patterns and support improvement strategies.

Data gathered by KDADS-CSP Regional Staff during the Quality Survey Process is provided quarterly to the KDADS-CSP Performance Improvement Review Committee [Chaired by the Performance Improvement Program Manager / staffed by PI Staff statewide] for evaluation and trending to identify areas for improvement. Upon completion of identified areas of improvement this information is compiled into an executive report (quarterly and annually) which is submitted to the Performance Improvement Executive Committee [Chaired by the Assistant Director KDADS-CSP] staffed by Waiver Program Managers, QA Program Manager and PI Program Manager]. The Performance Improvement Executive Committee generates corrective action planning and improvement planning which is submitted to the Director of KDADS-CSP, the Medicaid Operating Agency, for review and approval/denial and sent to the Kansas Department of Health and Environment via the KDHE Long Term Care Committee for review by the State Medicaid Agency (SSMA). The approval/denial from the Director of KDADS/CSP would be returned to the Performance Improvement Executive Committee for corrective action or planning for implementation of improvement. Additionally, KDADS/CSP is in attendance at the monthly Long Term Care Committee meeting to provide updates with regard to waiver quality processes and HCBS issues as they arise. These surveys, reviews and remediation 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. (The QIS is reviewed at least annually, and adjusted as necessary based upon that review.) 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.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:

Number and percent of unexpected deaths for which review/investigation resulted in the identification of preventable causes N=Number of unexpected deaths for which review/investigation resulted in the identification of non-preventable causes D=Number of unexpected deaths

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <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 checked="" type="checkbox"/> Other Specify: Community Developmental Disability Organizations (CDDOs); Managed Care Organizations (MCOs)	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<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 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: _____

Performance Measure:

Number and percent of unexpected deaths for which review/investigation followed the appropriate policies and procedures N=Number of unexpected deaths for which review/investigation followed the appropriate policies and procedures as in the approved waiver D=Number of unexpected deaths

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
<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 checked="" type="checkbox"/> Other Specify: Community Developmental Disability Organizations (CDDOs); Managed Care Organizations (MCOs)	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of unexpected deaths for which the appropriate follow-up measures were taken N=Number of unexpected deaths for which the appropriate follow-up measures were taken as in the approved waiver D=Number of unexpected deaths

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" 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 checked="" type="checkbox"/> Other Specify: Community Developmental Disability Organizations (CDDOs); Managed Care Organizations (MCOs)	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: _____
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: _____
	<input type="checkbox"/> Other Specify: _____	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<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 of this measure's results as determined by the State operating agency	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
	<input type="checkbox"/> Other Specify: _____

Performance Measure:

Number and percent of waiver participants who have a disaster red flag designation with a related disaster backup plan N=Number of waiver participants who have a disaster red flag designation with a related disaster backup plan D=Number of waiver participants with a red flag designation

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
<input checked="" 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 checked="" type="checkbox"/> Other Specify: Community Development Disability Organizations (CDDOs); Managed Care Organizations (MCOs)	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: _____
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: _____
	<input type="checkbox"/> Other Specify: _____	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<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 checked="" type="checkbox"/> Other Specify: KanCare MCOs 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:

Performance Measure:

Number and percent of waiver participants who received information on how to report suspected abuse, neglect, or exploitation
N=Number of waiver participants who received information on how to report suspected abuse, neglect, or exploitation
D=Number of waiver participants interviewed by QMS staff or whose records are reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record Interviews and Customer Interviews

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 checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input checked="" type="checkbox"/> Other Specify: Community Developmental Disability Organizations (CDDOs); Managed Care Organizations (MCOs)	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Proportionate by MCO

	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: _____
	<input type="checkbox"/> Other Specify: _____	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<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 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: _____

Performance Measure:

Number and percent of participants' reported critical incidents that were initiated and reviewed within required time frames N=Number of participants' reported critical incidents that were initiated and reviewed within required time frames as specified in the approved waiver D=Number of participants' reported critical incidents

Data Source (Select one):

Other

If 'Other' is selected, specify:

Critical Incident Management System

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
<input checked="" 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 checked="" type="checkbox"/> Other Specify: Community Developmental Disability Organizations (CDDOs); Managed Care Organizations (MCOs)	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of reported critical incidents requiring review/investigation where the State adhered to its follow-up measures
 $N = \text{Number of reported critical incidents requiring review/investigation where the State adhered to the follow-up methods as specified in the approved waiver}$
 $D = \text{Number of reported critical incidents}$

Data Source (Select one):

Other

If 'Other' is selected, specify:

Critical Incident Management System

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" 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 checked="" type="checkbox"/> Other Specify: Community Developmental Disability Organizations (CDDOs); Managed Care Organizations (MCOs)	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<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 of this measure's results as determined by the State operating agency	<input checked="" type="checkbox"/> Annually

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: _____

Performance Measure:

Number and percent of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver N=Number of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver D=Number of restraint applications, seclusion or other restrictive interventions

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

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

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of unauthorized uses of restrictive interventions that were appropriately reported N=Number of unauthorized uses of restrictive interventions that were appropriately reported D=Number of unauthorized uses of restrictive interventions

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

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

	<input type="checkbox"/> Other Specify:
--	---------------------------------------------------

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of waiver participants who received physical exams in accordance with State policies N=Number of HCBS participants who received physical exams in accordance with State policies. D=Number of HCBS participants whose service plans were reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

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

Community Developmental Disability Organizations (CDDOs); Managed Care Organizations (MCOs)		Proportionate by MCO
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: _____
	<input type="checkbox"/> Other Specify: _____	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<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 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: _____

- 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 consumers, advocacy organizations, provider groups and other interested stakeholders to monitor the state quality strategy and performance standards and discuss priorities for remediation and improvement. The state quality improvement strategy includes protocols to review cross-service system data to identify trends and opportunities for improvement related to all Kansas waivers, policy and procedure development and systems change initiatives. Data gathered by KDADS Regional Staff during the Quality Survey Process is compiled quarterly for evaluation and trending to identify areas for improvement. Upon completion of identified areas of improvement this information is compiled into reports and shared both internally and externally, including with KDHE. As the KanCare program is operationalized, staff of the three plans will be 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.
 KDADS-Community Services and Programs is responsible for oversight of critical events/incidents and unauthorized use of restraint/restrictive procedures, in accordance with Kansas regulatory and statutory requirements. Oversight of regulatory standards and statute is conducted by KDADS Field Staff.

DCF-Child Protective Services (CPS) and DCF-Adult Protective Services (APS) maintain data bases of all critical incidents and events and make available the contents of the data base to KDADS and KDHE through quarterly reporting.

KDADS and DCF-Child Protective Services (CPS) and DCF-Adult Protective Services (APS) meet on a quarterly basis to trend data, develop evidence-based decisions, and identify opportunities for provider improvement and/or training.

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(<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
<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: Community Developmental Disability Organizations (CDDOs); KanCare Managed Care Organizations (MCOs)	<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. Timelines

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

- No

Yes

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

Appendix H: Quality Improvement Strategy (1 of 2)

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

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

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

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

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I), a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

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

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Kansas Department of Health and Environment (KDHE), specifically the Division of the Division of Health Care Finance, operates as the single State Medicaid Agency, and the Kansas Department for Aging and Disability Services (KDADS) serve as the operating agency. The two agencies collaborate in developing operating agency priorities to meet established HCBS assurances and minimum standards of service.

Through KDADS's Quality Review (QR) process, a statistically significant random sample of HCBS participants is interviewed and data collected for meaningful consumer feedback on the HCBS program. KDADS reviews a statistically significant sample of participants for the I/DD waiver population (KS.0224) and the other affected waiver populations under the Quality Improvement Strategy. These include the Frail Elderly (KS.0303), Physical Disability (KS.304), Serious Emotional Disturbance (KS.0320), Autism (KS.0476), Traumatic Brain Injury (KS.4164) and Technology Assisted (KS.4165) waiver populations. The sampling will be done for each waiver individually as will all of the data aggregation, analysis and reporting.

The QR process includes review of participant case files against a standard protocol to ensure policy compliance. KDADS Program Managers regularly communicate with Managed Care Organizations, (MCOs), the functional eligibility contractor and HCBS service providers, thereby ensuring continual guidance on the HCBS service delivery system.

KDADS Quality Review staff collects data based on participant interviews and case file reviews. KDADS Program Evaluation staff reviews, compiles, and analyzes the data obtained as part of the Quality Review process at both the statewide and MCO levels to initiate the HCBS Quality Improvement process. This information is provided quarterly and annually to KDADS management, KDHE's Long-Term Care Committee and the KanCare Interagency Monitoring Team (IMT), and the KanCare Managed Care Organizations and contracted assessor organizations. De-identified results, to exclude any personally-identifying information, are available upon request to other interested parties. In addition to data captured through the QR process, other data is captured within the various State systems, the functional eligibility contractor's systems as well as the Managed Care Organizations' systems. On a routine basis, KDADS' Program Evaluation staff extracts or obtains data from the various systems and aggregates it, evaluating it for any trends or discrepancies as well as any systemic issues. Examples include, but are not limited to, reports focusing on qualified assessors and claims data.

A third major area of data collection and aggregation focuses on the agency's critical incident management system. KDADS worked with Adult Protective Services (APS), a division within the Kansas Department for Children and Families (formerly the Kansas Department of Social and Rehabilitation Services) and the Managed Care Organizations and established a formal process for oversight of critical incidents and events, including reports generated for trending, the frequency of those reports, as well as how this information is communicated to DHCF-KDHE, the single state Medicaid agency. The system allows for uniform reporting and prevents any possible duplication of reporting to both the MCOs and the State. The Adverse Incident Reporting System, also known as AIR, facilitates ongoing quality improvement to ensure the health and safety of individuals receiving services by agencies or organizations licensed or funded by KDADS and provides information to improve policies, procedures and practices. Incidents are reported within 24 hours of providers becoming aware of the occurrence of the adverse incident. Examples of adverse incidents reported in the system include, but are not limited to, unexpected deaths, medication misuse, abuse, neglect and exploitation.

For all three main areas of data collection and aggregation, KDADS' Program Evaluation staff collects data, aggregates it, analyzes it and provides information regarding discrepancies and trends to Program staff, Quality Review staff and other management staff. If systemic issues are found, several different remediation strategies are utilized, depending upon the nature, scope and severity of the issues. Strategies include, but are not limited to, training of the QR staff to ensure the protocols are utilized correctly, protocol revisions to capture the appropriate data and policy clarifications to MCOs to ensure adherence to policy. Additionally, any remediation efforts might be MCO-specific or provider-specific, again depending on the nature, scope

and severity of the issue(s).

WORK PLAN:

The Operating Agency will convene an internal HCBS Quality Improvement Committee, comprised of Program Managers, Quality Review staff, and Program Evaluation Staff, to meet quarterly to evaluate trends reflected in the HCBS HCBSQuality Review Reports and identify areas for improvement beginning April 2014.

The KLO 2 (Kansas Lifestyle Outcomes 2) is the quality survey tool used to monitor safeguards and standards under the waiver. State field staff (Quality Management Specialists or QMS) are accountable for completion of annual on-site, in-person review of waiver participants that focuses on four components that include opportunities of Choice to support and increase independence, productivity, integration and inclusion; Individual Rights and Responsibilities, personal health and safety is maintained and if the use of psychotropic medications or other restrictions are practiced are safeguards are in place. The process includes State field staff seeing/interviewing the individual, provider staff, see them in their home or work site, and if applicable, interviewing their parent/guardian. All performance standards identified in the current Quality Process have been developed in partnership with consumers, advocates, provider organizations and state operating and authority agencies to monitor waiver assurances and minimum standards. Quality data is shared with Kansas Health Policy Authority, (KHPA), the single state Medicaid agency, at the Long-Term Care (LTC) Workgroup meetings. Any quality concerns outside of the data collected may also be raised at the LTC monthly meeting. Quality issues may be discussed anytime with the KHPA Program Integrity Manager or at various other interagency meetings.

ii. System Improvement Activities

Responsible Party (check each that applies):	Frequency of Monitoring 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"/> Quality Improvement Committee	<input checked="" type="checkbox"/> Annually
<input checked="" type="checkbox"/> Other Specify: KanCare Managed Care Organizations (MCOs)	<input type="checkbox"/> Other Specify:

b. System Design Changes

- i.** Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State’s targeted standards for systems improvement.

The Kansas Department on Aging (KDADS) and the Division of Health Care Finance within the Kansas Department of Health and Environment monitor and analyze the effectiveness of system design changes using several methods, dependent on the system enhancement being implemented. System changes having a direct impact on HCBS participants are monitored and analyzed through KDADS's Quality Review process. Additional questions may be added to the HCBS Customer Interview Protocols to obtain consumer feedback, or additional performance indicators and policy standards may be added to the HCBS Case File Quality Review Protocols. Results of these changes are collected, compiled, reviewed, and analyzed quarterly and annually.

Based on information gathered through the analysis of the Quality Review data and daily program administration, KDADS Program Managers determine if the issues are systemic or an isolated instance or issue. This information is reviewed to determine if training to a specific Managed Care Organization is sufficient, or if a system change is required.

The Kansas Assessment Management Information System (KAMIS) is the official electronic repository of

data about KDADS customers and their received services. This customer-based data is used by KDADS and the MCOs to coordinate activities and manage HCBS programs. System changes are made to KAMIS to enhance the availability of information on participants and performance. Improvements to the KAMIS system are initiated through comments from stakeholders, KDADS Program Managers, and Quality Review staff, and approved and prioritized by KDADS management. Effectiveness of the system design change is monitored by KDADS's Program Managers, working in concert with KDADS's Quality Review and Program Evaluation staff.

DHCF-KDHE contracts with Hewlett Packard (HP) to manage the Medicaid Management Information System (MMIS). Improvements to this system require DHCF-KDHE approval of the concept and prioritization of the change. KDADS staff work with DHCF-KDHE and HP staff to generate recommended systems changes, which are then monitored and analyzed by HP and KDADS to ensure the system change operates as intended and meets the desired performance outcome.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Following is the process KDADS will use to identify and implement Quality Improvements and periodically evaluate the state's Quality Improvement Strategy:

WORK PLAN:

The Operating Agency will convene an internal HCBS Quality Improvement Committee, comprised of Program, Quality Review, and Program Evaluation Staff, to meet quarterly to evaluate trends reflected in the HCBS HCBSQuality Review Reports and identify areas for improvement beginning April 2014.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Based on signed provider agreements, each HCBS provider is required to permit the Kansas Department of Health and Environment, the Kansas Department for Aging and Disabilities (KDADS), their designee, or any other governmental agency acting in its official capacity to examine any records and documents that are necessary to ascertain information pertinent to the determination of the proper amount of a payment due from the Medicaid program. Additionally, the Division of Legislative Post Audit contracts with an independent accounting firm to complete Kansas' statewide single audit on an annual basis. The accounting firm must comply with all requirements contained in the single audit act. The Medicaid program, including all home and community based services waivers is a required component of the single state audit. Independent audits of the waiver will look at cost-effectiveness, the quality of services, service access, and the substantiation of claims for HCBS payments. These issues are addressed in a variety of ways, including: statewide single annual audit; annual financial and other audits of the KanCare MCOs; encounter data, quality of care and other performance reviews/audits; and audits conducted on HCBS providers. There are business practices of the state that result in additional ongoing audit activities that provide infrastructure/safeguards for the HCBS programs, including:

- a. Because of other business relationships with the state, each of the following HCBS provider entities are required to obtain and submit annual financial audits, which are reviewed and used to inform their Medicaid business with Kansas: Area Agencies on Aging; Community Mental Health Centers; Community Developmental Disability Organizations; and Centers for Independent Living.
- b. As a core provider requirement, FMS providers must obtain and submit annual financial audits, which are reviewed and used to monitor their Medicaid business with Kansas.

Under the KanCare program, payment for services is being made through the monthly pmpm paid by the state to the contracting MCOs. (The payments the MCOs make to individual providers, who are part of their networks and subject to contracting protections/reviews/member safeguards.) Payments to MCOs are subject to ongoing monitoring and reporting to CMS, consistent with the Special Terms and Conditions issued with approval of the related 1115 waiver. Those STCs include both monitoring of budget neutrality as well as general financial requirements, and also a robust evaluation of that demonstration project which addresses the impact of the KanCare program on access to care, the quality, efficiency, and coordination of care, and the cost of care.

In addition, these services - as part of the comprehensive KanCare managed care program - will be part of the corporate compliance/program integrity activities of each of the KanCare MCOs. That includes both monitoring and enforcement of their provider agreements with each provider member of their network and also a robust treatment, consistent with federal regulation and state law requirements, of prevention, detection, intervention, reporting, correction and remediation program related to fraud, waste, abuse or other impropriety in the delivery of Medicaid services under the KanCare program. The activities include comprehensive utilization management, quality data reporting and monitoring, and a compliance officer dedicated to the KanCare program, with a compliance committee that has access to MCO senior management. As those activities are implemented and outcomes achieved, the MCOs will be providing regular and ad hoc reporting of results. KDHE will have oversight of all portions of the program and the KanCare MCO contracts, and will collaborate with KDADS regarding HCBS program management, including those items that touch on financial integrity and corporate compliance/program integrity. The key component of that collaboration will be through the KanCare Interagency Monitoring Team, an important part of the overall state's KanCare Quality Improvement Strategy, which will provide quality review and monitoring of all aspects of the KanCare program – engaging program management, contract management, and financial management staff from both KDHE and KDADS.

Some of the specific contractual requirements associated with the program integrity efforts of each MCO include:

Coordination of Program Integrity Efforts.

The CONTRACTOR shall coordinate any and all program integrity efforts with KDHE/DHCF personnel and Kansas' Medicaid Fraud Control Unit (MFCU), located within the Kansas Attorney General's Office. At a minimum, the CONTRACTOR shall:

- a. Meet monthly, and as required, with the KDHE/DHCF staff and MFCU staff to coordinate reporting of all instances of credible allegations of fraud, as well as all recoupment actions taken against providers;
- b. Provide any and all documentation or information upon request to KDHE/DHCF or MFCU related to any aspect of this contract, including but not limited to policies, procedures, subcontracts, provider agreements, claims data, encounter data, and reports on recoupment actions and receivables;
- c. Report within two (2) working days to the KDHE/DHCF, MFCU, and any appropriate legal authorities any evidence indicating the possibility of fraud and abuse by any member of the provider network; if the CONTRACTOR fails to report any suspected fraud or abuse, the State may invoke any penalties allowed under this contract including, but not limited to, suspension of payments or termination of the contract. Furthermore, the enforcement of penalties under the contract shall not be construed to bar other legal or equitable remedies which may be available to the State or MFCU for noncompliance with this section;
- d. Provide KDHE/DHCF with a quarterly update of investigative activity, including corrective actions taken;
- e. Hire and maintain a staff person in Kansas whose duties shall be composed at least 90% of the time in the oversight and management of the program integrity efforts required under this contract. This person shall be designated as the Program Integrity Manager. The program integrity manager shall have open and immediate access to all claims, claims processing data and any other electronic or paper information required to assure that program integrity activity of the CONTRACTOR is sufficient to meet the requirements of the KDHE/DHCF. The duties shall include, but not be limited to the following:
 - (1) Oversight of the program integrity function under this contract;
 - (2) Liaison with the State in all matters regarding program integrity;
 - (3) Development and operations of a fraud control program within the CONTRACTOR claims payment system;
 - (4) Liaison with Kansas' MFCU;
 - (5) Assure coordination of efforts with KDHE/DHCF and other agencies concerning program integrity issues.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability

State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 provider claims that are coded and paid in accordance with the state's approved reimbursement methodology
N=Number of provider claims that are coded and paid in accordance with the state's approved reimbursement methodology
D=Total number of provider claims paid

Data Source (Select one):

Other

If 'Other' is selected, specify:

DSS/DAI Encounter Data

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" 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 checked="" type="checkbox"/> Other Specify: Managed Care Organizations (MCOs)	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

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

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 type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: KanCare Managed Care Organizations (MCO) participate in the 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: _____

Performance Measure:

Number and percent of clean claims that are paid by the managed care organization within the timeframes specified in the contract
 $N = \text{Number of clean claims that are paid by the managed care organization within the timeframes specified in the contract}$
 $D = \text{Total number of provider claims}$

Data Source (Select one):

Other

If 'Other' is selected, specify:

DSS/DAI encounter data

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
<input checked="" 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 checked="" type="checkbox"/> Other Specify: KanCare Managed Care Organizations (MCOs)	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: _____
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: _____
	<input type="checkbox"/> Other	

Specify:

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<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 checked="" type="checkbox"/> Other Specify: KanCare MCOs 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:

Performance Measure:

Number and percent of payment rates that were certified to be actuarially sound by the State's actuary and approved by CMS N=Number of payment rates that were certified to be actuarially sound by the State's actuary and approved by CMS D=Total number of capitation (payment) rates

Data Source (Select one):

Other

If 'Other' is selected, specify:

Rate Setting Documentation

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

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

Data Aggregation and Analysis:

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

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

The state established a KanCare Interagency Coordination and Contract Monitoring (KICCM) to ensure effective interagency coordination as well as overall monitoring of MCO contract compliance. This work will be governed by the comprehensive state Quality Improvement Strategy for the KanCare program, a key component of which is the Interagency Monitoring Team that engages program management, contract management and financial management staff of both KDHE and KDADS.

b. Methods for Remediation/Fixing Individual Problems

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

These measures and collection/reporting protocols, together with others that are part of the 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 <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<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 checked="" type="checkbox"/> Other Specify: KanCare MCOs contracting with the State of Kansas	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: _____

c. Timelines

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

- No**
- Yes**

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

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.

K.S.A. 39-1801-et.al., aka The Developmental Disabilities Reform Act (DDRA) mandates the establishment of a

system of funding, quality assurance and contracting. Further, the statute requires an independent, professional review of the rate structures on a biennial basis resulting in a recommendation to the legislature regarding rate adjustments. The recommendation shall be adequate to support A) A system of employee compensation competitive with local conditions; B) training and technical support to attract and retain qualified employees, C) a quality assurance process which is responsive to consumer's needs and which maintains the standards of quality service. The State Medicaid agency solicits public comments regarding the rate determination methods through publication in the Kansas Public Register. This rate determination method is used for all HCBS-I/DD services regardless of whether the service is reimbursed through a tiered rate or a single rate.

Throughout the history of the Kansas HCBS-I/DD waiver, Kansas has used tiered rates to reimburse providers of many waiver services including day and residential supports. The initial rates were developed based on the recommendations of an actuarial contracted with by the State. In 1995, the Kansas Legislature passed the Developmental Disabilities Reform Act. Among other things, as stated above, the Act requires KDADS to conduct biennial rate studies. A requirement of the study is to make recommendations to the Kansas Legislature regarding the adequacy of reimbursement rates.

Based on the results of these rate studies, the Kansas Legislature, in the past, has appropriated money to the Department For Aging and Disability Services for the specific purpose of adjusting reimbursement rates.

A sheet that includes all rates for all waiver services is available to providers and participants upon request.

Under the KanCare comprehensive managed care program, capitation rates are established consistent with federal regulation requirements, by actuarially sound methods, which take into account utilization, medical expenditures, program changes and other relevant environmental and financial factors. The resulting rates are certified to and approved by CMS.

Under KanCare, the State sets the floor HCBS service rates which serve as the minimum MCOs are required to pay providers. These rates, as established by the State, are available on the KMAP website.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Claims for services are submitted to the MCOs directly from waiver provider agencies or from Financial Management Service (FMS) agencies for those individuals self-directing their services. All claims are either submitted through the EVV system, the State's front end billing solution or directly to the MCO either submitted through paper claim format or through electronic format. Claims for services required in the EVV system are generated from that system. Capitated payments in arrears are made only when the consumer was eligible for the Medicaid waiver program during the month.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

- c. Certifying Public Expenditures** (*select one*):

- No. State or local government agencies do not certify expenditures for waiver services.**
- Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

Select at least one:

- Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-a.*)

Certified Public Expenditures (CPE) of Local Government Agencies.

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-b.*)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

- d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

A capitated payment is made to the MCOs for each month of Waiver eligibility. This is identified through KAECES, the State's eligibility system (MMIS). The state also is requiring the MCOs to utilize the State's contracted Electronic Visit Verification for mandatory Waiver services. Those Waiver services are billed through EVV based on electronically verified provided services, connected to the consumer's plan of care detailing authorized services. All mandated services must be billed through the EVV system. Reviews to validate that services were in fact provided as billed is part of the financial integrity reviews described above in Section I-1.

The Medicaid Management Information System (MMIS) verifies an individual is eligible for Medicaid payment on the date of service. A capitated payment is made to the MCOs for each month of Waiver eligibility. This is identified through KAECES, the State's eligibility system (MMIS). The MCOs are responsible for ensuring participants are eligible to receive Medicaid waiver payments prior to authorizing a service on the plan of care. The MCOs are required to ensure payments are made for services that are identified in the approved plan of care. In order to monitor service delivery, the State requires MCOs to utilize the Electronic Visit Verification (EVV) system for authorization of services. The system is utilized to authenticate services has been provided, and allows claims to be submitted against authorized services in the system.

Reviews to validate that services were in fact provided as billed is captured in the EVV system and can be utilized as part of the financial integrity reviews described in Section I-1. The EVV system enables State staff real time access in order to monitor service authorizations, utilization and track service deliveries.

- e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

- a. Method of payments -- MMIS (*select one*):**

- Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

The MMIS Managed Care system assigns beneficiaries to one of the three KanCare Plans. Each assignment generates an assignment record, which is shared with the plans via an electronic record. At the end of each month, the MMIS Managed Care System creates a capitation payment, paid in arrears, for each beneficiary who was assigned to one of the plans. Each payment is associated to a rate cell. The rate cells, defined by KDHE as part of the actuarial rate development process which is certified to and approved by CMS, each have a specific dollar amount established by actuarial data for a specific cohort and an effective time period for the rate.

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

- b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

All of the waiver services in this program are included in the state's contract with the KanCare MCOs.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

- c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for

expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- No. The State does not make supplemental or enhanced payments for waiver services.**
- Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

- No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: *Complete item I-3-e.*

Waiver payments are made to Community Developmental Disability Organizations which are specifically established by state law as the instrumentalities of government to oversee and manage the delivery of services to persons with mental retardation and/or developmental disabilities. This designation makes these entities public providers.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

- The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

No. The monthly capitated payments to the MCOs are not reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**

- The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

- a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

- Appropriation of State Tax Revenues to the State Medicaid agency**
- Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I -2-c:

The non-federal share of the waiver expenditures is from direct state appropriations to the Department for Aging and Disability Services (KDADS), through agreement with the Single State Medicaid Agency, Kansas Department of Health and Environment(KDHE), as of July 1, 2012. The non-federal share of the waiver expenditures are directly expended by KDADS. Medicaid payments are processed by the State's fiscal agent through the Medicaid Management Information System using the InterChange STARS Interface System (iCSIS). iCSIS contains data tables with the current federal and state funding percentages for all funding types. State agencies are able to access iCSIS's reporting module to identify payments made by each agency. KDHE – Division of Health Care Finance draws down federal Medicaid funds for all agencies based on the summary reports from iCSIS. Interfund transfers to the other state agencies are based on finalized fund summary reports. The full rate will be expended on capitation payments in the KanCare program.

- Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

- b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One:*

Not Applicable. There are no local government level sources of funds utilized as the non-federal share.

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one:*

None of the specified sources of funds contribute to the non-federal share of computable waiver costs

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

No services under this waiver are furnished in residential settings other than the private residence of the individual.

As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

When establishing reimbursement rates as described in Appendix I2 - a., no expenses associated with room and board are considered. The costs of room and board are not a consideration when determining reimbursement

rates. Only direct service costs are considered.

Payments to providers for room and board are not processed through the Medicaid system and are therefore not included in any Medicaid cost reports.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C -3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

- Nominal deductible**
- Coinsurance**
- Co-Payment**
- Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

- No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
- Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the

Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	34277.43	11340.00	45617.43	69349.00	3333.00	72682.00	27064.57
2	34887.15	11567.00	46454.15	70736.00	3400.00	74136.00	27681.85
3	34916.78	5877.00	40793.78	67838.00	3137.00	70975.00	30181.22
4	35359.84	5994.00	41353.84	69195.00	3200.00	72395.00	31041.16
5	43622.59	6812.00	50434.59	85485.00	5694.00	91179.00	40744.41

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

- a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (from Item B -3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		ICF/IID	
Year 1	8352	8352	
Year 2	8652	8652	
Year 3	8952	8952	
Year 4	9252	9252	
Year 5	9100	9100	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

- b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Average Length of Stay was calculated by using the total days of waiver coverage for SFY2012 (7/1/2011 - 6/30/2012) : 3,366,503, divided by the unduplicated number served: 9,552, or 352 ALOS.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

- c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Factor D was estimated by utilizing data from the Kansas MMIS system and reflects the average HCBS waiver service cost and utilization for DD waiver participants for the state fiscal years July 2009 through June 2012. This average expenditure was then projected to Year 5 of the waiver.

- ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' was estimated by utilizing data from the Kansas MMIS system and reflects the average acute care cost and utilization for DD waiver participants for the state fiscal years July 2009 through June 2012. This average expenditure was then projected to Year 5 of the waiver. Note: The historical data from July 2009-June 2012 does not include the costs of prescribed drugs paid for by Medicare.

- iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G was estimated by utilizing data from the Kansas MMIS system and reflects the average ICF/MR cost and utilization for ICF/MR members for the state fiscal years July 2009 through June 2012. This average expenditure was projected to year 5 of the waiver under the assumption these services would be provided in a FFS environment at an average annual trend of 1.0%.

- iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' was estimated by utilizing data from the Kansas MMIS system and reflects the average acute care cost and utilization for ICF/MR members for the state fiscal years July 2009 through June 2012. This average expenditure was projected to year 5 of the waiver under the assumption these services would be provided in a FFS environment at an average annual trend of 5.3%.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “*manage components*” to add these components.

Waiver Services	
Day Supports	
Overnight Respite Care	
Personal Assistant Services	
Residential Supports	
Supported Employment	
Financial Management Services (FMS)	
Assistive Services	
Medical Alert Rental	
Sleep Cycle Support	
Specialized Medical Care	
Supportive Home Care	
Wellness Monitoring	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Supports Total:							68817062.16
Day Supports	<input type="checkbox"/>	1 unit = 1 day	5081	209.00	62.22	66073222.38	
Pre-Vocational Supports	<input type="checkbox"/>	1 unit = 1 day	211	209.00	62.22	2743839.78	
Overnight Respite Care Total:							18279.40
Overnight Respite Care	<input type="checkbox"/>	1 unit = 1 day	21	17.24	50.49	18279.40	
Personal Assistant Services Total:							2688160.00
Personal Assistant Services	<input type="checkbox"/>	1 unit = 15 minutes	200	5072.00	2.65	2688160.00	
Residential Supports Total:							177798179.99
Residential Supports (child)	<input type="checkbox"/>	1 unit = 1 day	279	321.78	86.70	7783632.95	
Residential Supports (adult)	<input type="checkbox"/>	1 unit = 1 day	4337	352.59	111.18	170014547.04	
Supported Employment Total:							222600.00
Supported Employment	<input type="checkbox"/>	1 unit = 15 minutes	25	3360.00	2.65	222600.00	
Financial Management Services (FMS) Total:							0.00
Financial Management Services (FMS)	<input type="checkbox"/>	1 unit = 1 month	0	0.00	0.01	0.00	
Assistive Services Total:							721410.30
Assistive Services	<input type="checkbox"/>	1 unit = 1 purchase	195	1.00	3699.54	721410.30	
Medical Alert Rental Total:							8720.25
Medical Alert Rental	<input type="checkbox"/>	1 unit = 1 month	55	10.57	15.00	8720.25	
Sleep Cycle Support Total:							658628.44
Sleep Cycle Support	<input type="checkbox"/>	1 unit = 1 day	98	253.42	26.52	658628.44	
Specialized Medical Care Total:							2115260.00
Specialized Medical Care	<input type="checkbox"/>	1 unit = 15 minutes	20	14588.00	7.25	2115260.00	
GRAND TOTAL:							286285130.41
Total Estimated Unduplicated Participants:							8352
Factor D (Divide total by number of participants):							34277.43
Average Length of Stay on the Waiver:							346

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supportive Home Care Total:							33010604.80
Supportive Home Care	<input type="checkbox"/>	1 unit = 15 minutes	2456	5072.00	2.65	33010604.80	
Wellness Monitoring Total:							226225.07
Wellness Monitoring	<input type="checkbox"/>	1 unit = 1 visit	1577	5.86	24.48	226225.07	
GRAND TOTAL:							286285130.41
Total Estimated Unduplicated Participants:							8352
Factor D (Divide total by number of participants):							<u>34277.43</u>
Average Length of Stay on the Waiver:							346

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Supports Total:							72310639.28
Day Supports	<input type="checkbox"/>	1 unit = 1 day	5234	209.00	63.46	69419274.76	
Pre-Vocational Supports	<input type="checkbox"/>	1 unit = 1 day	218	209.00	63.46	2891364.52	
Overnight Respite Care Total:							19532.92
Overnight Respite Care	<input type="checkbox"/>	1 unit = 1 day	22	17.24	51.50	19532.92	
Personal Assistant Services Total:							3423600.00
Personal Assistant Services	<input type="checkbox"/>	1 unit = 15 minutes	250	5072.00	2.70	3423600.00	
Residential Supports Total:							186143925.24
Residential Supports (child)	<input type="checkbox"/>	1 unit = 1 day	287	321.78	88.00	8126875.68	
Residential Supports (adult)	<input type="checkbox"/>	1 unit = 1 day	4468	352.59	113.00	178017049.56	
GRAND TOTAL:							301843627.90
Total Estimated Unduplicated Participants:							8652
Factor D (Divide total by number of participants):							<u>34887.15</u>
Average Length of Stay on the Waiver:							346

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Employment Total:							362880.00
Supported Employment	<input type="checkbox"/>	1 unit = 15 minutes	40	3360.00	2.70	362880.00	
Financial Management Services (FMS) Total:							0.00
Financial Management Services (FMS)	<input type="checkbox"/>	1 unit = 1 month	0	0.00	0.01	0.00	
Assistive Services Total:							758373.00
Assistive Services	<input type="checkbox"/>	1 unit = 1 purchase	201	1.00	3773.00	758373.00	
Medical Alert Rental Total:							9037.35
Medical Alert Rental	<input type="checkbox"/>	1 unit = 1 month	57	10.57	15.00	9037.35	
Sleep Cycle Support Total:							692356.11
Sleep Cycle Support	<input type="checkbox"/>	1 unit = 1 day	101	253.42	27.05	692356.11	
Specialized Medical Care Total:							3238536.00
Specialized Medical Care	<input type="checkbox"/>	1 unit = 15 minutes	30	14588.00	7.40	3238536.00	
Supportive Home Care Total:							34646832.00
Supportive Home Care	<input type="checkbox"/>	1 unit = 15 minutes	2530	5072.00	2.70	34646832.00	
Wellness Monitoring Total:							237916.00
Wellness Monitoring	<input type="checkbox"/>	1 unit = 1 visit	1624	5.86	25.00	237916.00	
GRAND TOTAL:							301843627.90
Total Estimated Unduplicated Participants:							8652
Factor D (Divide total by number of participants):							34887.15
Average Length of Stay on the Waiver:							346

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Supports Total:							74525583.66
Day Supports	<input type="checkbox"/>	1 unit = 1 day	5619	209.00	63.46	74525583.66	
Pre-Vocational Supports	<input type="checkbox"/>	1 unit = 1 day	0	0.00	0.01	0.00	
Overnight Respite Care Total:							20420.78
Overnight Respite Care	<input type="checkbox"/>	1 unit = 1 day	23	17.24	51.50	20420.78	
Personal Assistant Services Total:							30395481.60
Personal Assistant Services	<input type="checkbox"/>	1 unit = 15 minutes	2270	5072.00	2.64	30395481.60	
Residential Supports Total:							195213972.75
Residential Supports (child)	<input type="checkbox"/>	1 unit = 1 day	296	321.78	90.00	8572219.20	
Residential Supports (adult)	<input type="checkbox"/>	1 unit = 1 day	4603	352.59	115.00	186641753.55	
Supported Employment Total:							508200.00
Supported Employment	<input type="checkbox"/>	1 unit = 15 minutes	55	3360.00	2.75	508200.00	
Financial Management Services (FMS) Total:							2610500.00
Financial Management Services (FMS)	<input type="checkbox"/>	1 unit = 1 month	2270	10.00	115.00	2610500.00	
Assistive Services Total:							796536.00
Assistive Services	<input type="checkbox"/>	1 unit = 1 purchase	207	1.00	3848.00	796536.00	
Medical Alert Rental Total:							9354.45
Medical Alert Rental	<input type="checkbox"/>	1 unit = 1 month	59	10.57	15.00	9354.45	
Sleep Cycle Support Total:							712921.14
Sleep Cycle Support	<input type="checkbox"/>	1 unit = 1 day	104	253.42	27.05	712921.14	
Specialized Medical Care Total:							3346487.20
Specialized Medical Care	<input type="checkbox"/>	1 unit = 15 minutes	31	14588.00	7.40	3346487.20	
GRAND TOTAL:							312575038.48
Total Estimated Unduplicated Participants:							8952
Factor D (Divide total by number of participants):							34916.78
Average Length of Stay on the Waiver:							346

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supportive Home Care Total:							4190486.40
Supportive Home Care	<input type="checkbox"/>	1 unit = 15 minutes	270	5072.00	3.06	4190486.40	
Wellness Monitoring Total:							245094.50
Wellness Monitoring	<input type="checkbox"/>	1 unit = 1 visit	1673	5.86	25.00	245094.50	
GRAND TOTAL:							312575038.48
Total Estimated Unduplicated Participants:							8952
Factor D (Divide total by number of participants):							34916.78
Average Length of Stay on the Waiver:							346

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Supports Total:							78575640.00
Day Supports	<input type="checkbox"/>	1 unit = 1 day	5784	209.00	65.00	78575640.00	
Pre-Vocational Supports	<input type="checkbox"/>	1 unit = 1 day	0	0.00	0.01	0.00	
Overnight Respite Care Total:							21929.28
Overnight Respite Care	<input type="checkbox"/>	1 unit = 1 day	24	17.24	53.00	21929.28	
Personal Assistant Services Total:							30395481.60
Personal Assistant Services	<input type="checkbox"/>	1 unit = 15 minutes	2270	5072.00	2.64	30395481.60	
Residential Supports Total:							204568509.00
Residential Supports (child)	<input type="checkbox"/>	1 unit = 1 day	305	321.78	92.00	9029146.80	
Residential Supports (adult)	<input type="checkbox"/>	1 unit = 1 day	4740	352.59	117.00	195539362.20	
GRAND TOTAL:							327149219.40
Total Estimated Unduplicated Participants:							9252
Factor D (Divide total by number of participants):							35359.84
Average Length of Stay on the Waiver:							346

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Employment Total:							658560.00
Supported Employment	<input type="checkbox"/>	1 unit = 15 minutes	70	3360.00	2.80	658560.00	
Financial Management Services (FMS) Total:							3132600.00
Financial Management Services (FMS)	<input type="checkbox"/>	1 unit = 1 month	2270	12.00	115.00	3132600.00	
Assistive Services Total:							839950.00
Assistive Services	<input type="checkbox"/>	1 unit = 1 purchase	214	1.00	3925.00	839950.00	
Medical Alert Rental Total:							9671.55
Medical Alert Rental	<input type="checkbox"/>	1 unit = 1 month	61	10.57	15.00	9671.55	
Sleep Cycle Support Total:							759246.32
Sleep Cycle Support	<input type="checkbox"/>	1 unit = 1 day	107	253.42	28.00	759246.32	
Specialized Medical Care Total:							3734528.00
Specialized Medical Care	<input type="checkbox"/>	1 unit = 15 minutes	32	14588.00	8.00	3734528.00	
Supportive Home Care Total:							4190486.40
Supportive Home Care	<input type="checkbox"/>	1 unit = 15 minutes	270	5072.00	3.06	4190486.40	
Wellness Monitoring Total:							262617.25
Wellness Monitoring	<input type="checkbox"/>	1 unit = 1 visit	1723	5.86	26.01	262617.25	
GRAND TOTAL:							327149219.40
Total Estimated Unduplicated Participants:							9252
Factor D (Divide total by number of participants):							35359.84
Average Length of Stay on the Waiver:							346

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Supports Total:							110003101.65
Day Supports	<input checked="" type="checkbox"/>	1 unit = 1 day	6705	230.10	71.30	110003101.65	
Pre-Vocational Supports	<input checked="" type="checkbox"/>	1 unit = 1 day	0	0.00	0.01	0.00	
Overnight Respite Care Total:							66135.27
Overnight Respite Care	<input checked="" type="checkbox"/>	1 unit = 1 day	48	23.11	59.62	66135.27	
Personal Assistant Services Total:							22489363.70
Personal Assistant Services	<input checked="" type="checkbox"/>	1 unit = 15 minutes	2824	2917.09	2.73	22489363.70	
Residential Supports Total:							231220622.42
Residential Supports (child)	<input checked="" type="checkbox"/>	1 unit = 1 day	58	295.99	143.75	2467816.62	
Residential Supports (adult)	<input checked="" type="checkbox"/>	1 unit = 1 day	5527	356.58	116.07	228752805.80	
Supported Employment Total:							6388.11
Supported Employment	<input checked="" type="checkbox"/>	1 unit = 15 minutes	27	75.59	3.13	6388.11	
Financial Management Services (FMS) Total:							3898500.00
Financial Management Services (FMS)	<input checked="" type="checkbox"/>	1 unit = 1 month	2825	12.00	115.00	3898500.00	
Assistive Services Total:							95839.20
Assistive Services	<input checked="" type="checkbox"/>	1 unit = 1 purchase	16	1.00	5989.95	95839.20	
Medical Alert Rental Total:							8864.68
Medical Alert Rental	<input checked="" type="checkbox"/>	1 unit = 1 month	53	10.77	15.53	8864.68	
Sleep Cycle Support Total:							720775.37
Sleep Cycle Support	<input checked="" type="checkbox"/>	1 unit = 1 day	86	267.34	31.35	720775.37	
Specialized Medical Care Total:							1954599.42
Specialized Medical Care	<input checked="" type="checkbox"/>	1 unit = 15 minutes	23	11705.59	7.26	1954599.42	
GRAND TOTAL:							396965535.30
Total Estimated Unduplicated Participants:							9100
Factor D (Divide total by number of participants):							43622.59
Average Length of Stay on the Waiver:							352

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supportive Home Care Total:							26284687.17
Supportive Home Care	<input checked="" type="checkbox"/>	1 unit = 15 minutes	2935	2697.47	3.32	26284687.17	
Wellness Monitoring Total:							216658.30
Wellness Monitoring	<input checked="" type="checkbox"/>	1 unit = 1 visit	1393	4.33	35.92	216658.30	
GRAND TOTAL:							396965535.30
Total Estimated Unduplicated Participants:							9100
Factor D (Divide total by number of participants):							43622.59
Average Length of Stay on the Waiver:							352