Implementation Steps for Statewide Transition Plan (STP) Workgroup Recommendations

Dementia Recommendations

Recommendation	What are recommended next steps for transition by March 2019? Other feedback may be requested in the State Response column.
1.1. Develop guidance on person-centered care planning that is specific to persons with dementia.	Use CEAL document, CMS guidance related to this (recently issued) and incorporate into January PCSP training. Also review full recommendations. Get input from providers who serve people in their homes with dementia, IDD providers serving people with dementia. Identify training resources and needs related to dementia in PCSP. Make sure consumers/consumer advocates are a part of the training process.
1.3. Review and identify differences in terminology and requirements concerning person-centered planning among different provider settings.	MCO has person centered plan, facility has negotiated services agreement. Is anyone crosswalkinig the different documents. **Step 1**- Terminology, forms, and functionality of those forms (what is addressed in the NSA, MCO plan, etc.) crosswalk. **Step 2**- share at training.
1.7. KABC recommends that the state review and adopt a "right to rent" statute for Medicaid waiver participants, similar to public housing	Suggestion (not a recommendation of the group): Independent assessment of person's needs to help determine whether the provider can meet needs. This isn't necessarily related to the Final Rule. Is there more we want to do to protect people served who have to transition? Also, LTC ombudsman. 30 days to transition from provider not complying may be too short. 60 may allow for a better transition.
1.8. KABC recommends that a complimentary internal hearing and process be created for older consumers as well as the right to an external hearing, such as an administrative state fair hearing.	From KDADS: KDADS Legal is working on the reglation for appeal rights for this (this goes together with 1.7).

1.12. KABC recommends that the state use the planning process to create the next generation of health promoting settings and services which will serve older adults with dementia and meet the requirements of the HCBS final setting rule	In the past we've used systems change as an opportunity for innovation, suggestion to use this as one of those opportunities. Talk to providers- what do we do to help you? Also, maybe not traditional providers. Think outside the box. People want to receive service in the community, how are we as a state going to support that? MCO obligation to support innovation and capacity. **Step 1.** Conversation with small groups of consumers, providers, MCO & State- how do we keep the HCBS System from collapsing? How do we innovate? **Step 2.** Cross sector workgroups to have a conversation about and plan for implementation. Don't walk away from the intent of the Rule, if not implemented.

2. Day Services & 3. Non-Integrated Employment Settings

Recommendation	What are recommended next steps for transition by March 2019? Other feedback may be requested in the State Response column.
2.2. Anyone participating in day services, and their natural supports, should receive annual counseling and training on benefits, other options, and resources available to help them achieve employment goals.	Study and initate Benefits Counseling to make this a waiver service. As part of the workgroup listed in 2.3 etc. below.
2.3. Day service setting- Individualized Community Integrated Day Services: Recipients have individualized schedules and spend the majority of their day services in the community 2.4. Day service setting- Facility Based Day Services: Day Services provided in a facility setting only when a person needs time-limited pre-vocational training, and only when such training is not available in community settings. 2.5. Day service setting- Individualized Day Service Plan Due to Exceptional Needs / Day service Exceptions based on individualized, ongoing need due to health/behavioral need or operation of a home based business. 3.4. Service definitions proposed by this subgroup	Review other state models for multiple service descriptions and incentive structures. Wisconsin model is one example (its benefits and limitations). Move toward more discrete system of options that promote the outcomes we desire. Steve Hall's report for the KCDD has a support waiver option that can be reviewed. Deliver the right amount of service at the right time. A support waiver might be all that is needed if greater supports are not required. Benefits counseling as well. NASDDDS provides technical assistance to guide the process. Include services for dual diagnosis (IDD and BH). This will be a barrier to integration. Environmental scan of services and delivery system. Those involved in this step include: Medicaid KDHE with financial expertise about current system; NASDDDS TA person; Working Healthy Representative; MCOs; Steven Hall of Griffen and Hammis; LEADS Center Federal Dept of Labor Contractor; Emplyment Systems Change Coalition; KDADS Commissions, VR; KCDD; Benchmarks: Beginning February 2017, identify and constitute work group; review

	(see full recommendations document) need to be consistent with other programs, rules and definitions used by the state. Terms need to mean the same thing.	exisiting systems to include input from persons served and service providers; review of report; identify recommended service categories and rate structure; review by KDHE finance for fiscal impact; feedback from providers and consumers regarding impact of planned changes; decision on part of KDHE and KDADS (with input from VR and DCF) on direction for recommended State Plan Ammendment (SPA) or waiver creation (by May 2018). Communication with persons served and providers include: Beginning in Summer 2017, preliminary education that system change is coming including public meetings, biweekly phone sessons with KDADS, provider training beginning with case managers. NASDDDS TA grant to assist with transition. (Kansas request being one of 15 states with transition assistance from NASDDS in January 2017.) Build system of communication that can provide updated information. Ongoing through March 2019. Include Self Advocate Coalition of Kansas; Families Together; CDDOs; populations from all waivers; MCOs.
3.10.	State should adopt the supported employment Waiver Integration Stakeholder Engagement (WISE) 2.0 workgroup recommendations for a new supported employment HCBS program, as outlined in this report. (See full recommendations report.)	
2.8.	Create a rate structure reflective of a business model that is maintainable for providers and supports the outcomes the state wants.	Include in steps for 2.3 through 2.5 etc., above. This process must look closely at incentives and disincentives to reaching desired outcomes based on pay structure. Explore "base rate structure" with point value for desired outcomes. When provider meets the outcome, rate increases. This approach or some other method of creating a sustainable system while promoting outcomes. May tie health management into the incentives. Mechanism (metric) to automatically force an increase when outcomes are achieved. Must create a way for providers to report outcomes. Look at other states at how they have incentivized preferred outcomes. Must include how to support (incentivize) long-term employment outcomes (not discontinuing payment once a person has obtained a specific level of employment (need for services change over time). Include key players from the employment community (HR, etc.) to address barriers and challenges to gaining and sustaining employment. Create ways for other state entities to support these outcomes.
3.11.	The entire system should be incentivized in order to fund the desired outcome of increased competitive, integrated employment for people with disabilities of all working ages. Kansas needs to funds the outcomes it desires. According to Kansas public policy, competitive, integrated employment is supposed to be the first, and desired, option. As one example, disability provider payments could be incentivized toward the outcome of competitive and integrated employment and perhaps away from a simple fee for service model.	
2.9.	Training should be available for providers, including direct care staff, about changes	Appropriate ADA training coordinated by State ADA Coordinator. This requires change in philosophy (and practicial application) of protection to inclusion (most

	critical component), waiver changes, use of non-traditional services, community inclusion, supported decision-making. KDADS training workgroup consisting of providers, Self Advocates, and successful parents/guardians to direct training efforts drawing upon Self Advocates, direct care staff as role models, successful parents/guardians, and training providers such as College of Direct Support, etc. Post successful Kansas narratives. Benchmarks: Start with development of training group and education about change in philosophy in 2017 before changes in waiivers and policies take place. Create a training schedule with priority content. Target education in youth transitioning into services and shape what they are demanding for services. This is not cost neutral. Some training entity will be needed. State of Kansas of needs to re-engage CMS to look into how training can be provided through mediciad Administrative Match or other funding source for innovation and training in order to meet this systems change demand.
2.14. Currently, when a provider is successful at achieving employment outcomes, they are penalized; this barrier should be removed.	Successful transition off of waiver services, loss of fee for service and becausue of the way the waiting list works, you are not assured of a new clients (income) or enough trained staff to support the same level of care that graduated out of service. Move someone into work then there is a fiscal cliff for both provider and person in service. Supports waiver would provide some service and allow the provider and client income on an ongoing basis.
3.5. There should be a specific effort to ensure there are no unintended consequences harming or adversely affecting the resources to carry out the Final Rule.	Incorporate this into all waiver and policy changes.
3.9. An overriding goal must be preserving and expanding service capacity in order to conform to the Final Rule. This does not mean simply	Current service provider capacity will need to adjust thus requiring early and frequent education about expected changes in services and policies. KDADS explore vocational services/supports may need to be provided through nontraditional

	preserving the status quo. It means preserving and expanding the capacity to empower and serve Kansans with disabilities in the most integrated setting. Doing this will take time, money and immediate attention by Kansas.	resources, training programs, or purchase of generic services to support vocational outcomes not provided by traditional service providers. Create incentives for targeted case management to be more creative in how vocational goals are supported. Work with CDDO Capacity Group to assess current capacity and needed (expanded) capacity. Develop common measures of capacity to meet new demands related anticipated changes. KDADS work closely with VR, End Dependence, Work Force Development, Employment First Commission, Department of Commerce and others to access capacity of larger systems that support vocational outcomes for targeted populations. Related quality assurance measures for all services will need to be developed between (KDADS, CDDOs and MCOs, Self Advocates). (Include this in policy sections sections.) Begin in February 2017 and ongoing.
3.12.	Kansas public policy needs to be evaluated to ensure it is consistent with the Final Rule toward the goal of community-based, integrated services. As an example, Article 63 envisions facility-based services. Rates and supports will need to be individualized in order to obtain the principles detailed in this report.	Article 63 focus on licensed services that changed at that time. What is not in Article 63 that needs to be included for example emergency based services, medication management? This is just one example. Should review all related waiver manual policies. Eg: Nothing in current regulations instructs a provider to do the employment based supports. Include: WSU CEI, State ADA Coordinator, Governor's Subcabinent on Disability Policy Subgroup, Legislative Research; providers and persons served, KDADS Legal Department; VR; Department of Commerse and Labor. Steps include: Constitute a work group; review how other states have addressed policies; review Governors Subcabinent report; collect and review existing policies; draft policy changes with stakeholder input; publish in draft form for review by workgroup and pubic comment; proceed with KDADS regulatory process. Proposed priority policies (broad strokes) ready to educate community and providers by May 2018. After CMS signes off on SPA and created waivers (October/November 2018) waivers (which serves as the policy) will be available for further education. Communication provided about policy changes to person served and providers throughout the process. Consider ways to do outreach to persons who may be elegible for services (such as new supports waiver).
3.13.	Policy and procedure changes need to ensure that non-integrated employment settings be limited to prevocational supports, be time-limited, goal-oriented, person-centered, and	Comensuate with recommendations in 3.12. That group will be charged with this specific area of policy review.

	used only when it is truly the most integrated setting. This stated policy to conform to the Final Rule mandate cannot be in name only. Kansas policy and procedures need to contain effective accountability mechanisms in order to ensure these principles are accomplished. Rates and supports will need to be individualized in order to obtain the principles detailed in this report. Kansas also needs are far more robust validation process in order to ensure that these principles are supported and change occurs (see Tennessee's transition plan).	
3.14.	Kansas public policy and procedure should focus on self-direction for disability services. This has been a cornerstone of Kansas disability policy and has been contained in Kansas law since the late 1980's [NOTE-insert the exact KSA HERE]. However, it has not been effectuated. This law focuses on self-direction, increased autonomy and control of funding for persons with disabilities to access their needed services and supports.	Comensuate with recommendations in 3.12. That group will be charged with this specific area of policy review.
3.16.	Recommend the creation of cross-age, cross-disability independent navigation, ombudsman and facilitation supports to help address the complexities of HCBS and related supports and activities, which have gotten more complex with the Final Rule. As an example, the WISE 2.0 subgroup of the services definition group recommended that TERF specialists (Transition, Employment, Resource Facilitation) be established and funded. The WISE 2.0 groups have also recommended navigation and ombudsman services. (See full recommendations report.)	
2.1.	Kansas is an employment first state and we encourage everyone to consider employment as the first option.	
2.6.	Final decisions should be based on data	
2.10.	Certification for day services providers – all providers (including current) are/will be certified- as part of certification, providers share plans for ensuring services are community integrated.	
2.11.	Accountability and communication; feedback loop to stakeholders	
3.15.	Detailed, on-going, extensive and robust outreach, communication and education plans must be developed and implemented regarding the Final Rule and its impact in Kansas. People with disabilities, families, many providers and support staff are completely	

	unaware of how the Final Rule will impact their lives.
3.7.	The state should tap existing expertise as they develop all of the needed tools and steps to comply with the Final Rule. This expertise includes providers, self-advocates, advocacy organizations, people with disabilities and families. The state needs to partner with these experts. Engagement with stakeholders needs to immediately occur to review those draft Waiver amendments prior to their submission for public comment.
2.12.	Goods and services option- allow for use of waiver services to purchase vocational instruction (welding lessons, classes, etc.)
2.13.	Technical assistance- PCSP utilization, family members and guardians about changes

4. PCSP

Recommendation	What are recommended next steps for transition by March 2019? Other feedback may be requested in the State Response column.
4.3. Need for transparency- current status, outcome of assessments, stakeholder engagement.	1. Current Status - Providers & TCM, having information about where we are in the PCSP process and where they fit in the process – have a targeted call with clearly defined roles between them to know who they are and what - According to Art. 63 and CMS the role of TCM is not to write the PCSP - How are we defining support plan and service plan? Clearly defining that and making sure that we are talking about the same thing. Understand what each plan does or doesn't do. The charge and purpose and necessity of each document. - Matrix of what form, by what, for what, for whom, who is responsible/lead, etc. - How each form/document/requirement fits what each entity is doing – don't lose the member focus and keep a level of integration between the entities. 2. Outcome of Assessments - Review of Minnesota plan on how they reported outcome of assessments. - What did TN do with PCSP? - Can we see provider assessment compliance data? 3. Stakeholder Engagement - Make the process more efficient for participants - Identify possible peer-to-peer support possibilities - Basic education for members about the process and where requirements are coming from

	- How to direct their process so they understand - Give members tools to organize their thoughts prior to meeting NOTE: If consumers are able to advocate for themselves that they are able to direct and at a time and at a place that is convenient for them.
4.4. Conflict of Interest- need more guidance related to conflict of interest. Create policies to mitigate COI in IDD & SED TCM service.	1. The SED WAF COI there is a waiver amendment that has been submitted – the MCO will be taking a larger role in writing the plan of care and assuring it's in compliance. 2. IDD – there has been no waiver amendment made. There have been no policy changes I'm aware of. - Get the status of the TCM policy.
4.5. Conflict Resolution- Identify strategies for conflict resolution	1. Identify/clarify appeals process. 2. If someone refuses to sign the plan, then what? Does that mean, are the consequences, etc. – Identify the plan to address this. 3. Identify what a signature indicates on the plan. 4. How the process is communicated in advance of a plan review. – 1 page when the assessment is scheduled telling them what to expect or something like that.
4.6. State Statutes, Regulations, or Policies- Require regulations and statute to reflect requirements of PCSP. Identify potential solutions to integrate ISP with PCSP to reduce overassessment of participants.	1. What is the status of the PCSP policy written in the transition plan? 2. Want the State to listen to and consider the wishes of the participant. 3. Changes to the ACH regulations to incorporate appeal rights – will utilize the reg. process. – check the status? Who is doing that? (kaberline or lisa m?) 4. Status of policy manual updates? Who is doing this? 5. Written agreement that applies to the landlord and tenant act? 6. Do we need a policy that outlines when a provider is unable to or unwilling to comply or is unable to remediate for final rule? 7. Identify who is responsible to provide a notice of action to the participants in the non-compliant setting of the status and next steps. 8. Modifications to the plan that require additional assurances (ie restriction) must be in the plan and informed consent. 9. Remediation steps if MCO PCSP is out of compliance.
4.9. Require initial & ongoing training of the documenter (qualification)	1. Could this be an ombudsman? Peer to peer? 2. Another matrix appropriate here for the MCOs and who develops it and they train who writes it? – The state controls who write it? 3. Consider and develop applicable topics – i.e. waiver specific topics/needs, plain

	language, scheduling to maximize people's time, accommodations, what is the final rule, etc.
4.10. Identify a consistent training model of PCSP statewide; prior to implementation of the new process, annually thereafter.	1. Provide parent/family/participant/stakeholder training on PCSP rights, rules, etc. 2. Rights document with each PCSP meeting w/the MCO
4.11. Stakeholder education is standardized so everyone gets the same information & Comprehensive educational guide about PCSP	1. 3 different MCOs have different variations of how they deliver PCSP – consider a chart of that mirrors the value added services that shows the variances in how they deliver PCSP? 2. Maximize existing "toolkits" (DD council) 3. Assure information is accessible across all platforms
4.12. In order to address COI – whenever possible the participant will facilitate their own PCSP; if unable their designated representative will facilitate. Qualified persons will document the PCSP; allow this person to work across waivers.	Note: allowing the person to work across waivers not relevant in regard to to the MCOs doing this work. 1. In training it should (MUST) be emphasized that the participant will facilitate their own plan development whenever possible. 2. In the 1-page handout, identify examples of conflict of interest and how to remedy. (examples include losing a service so someone can save money or being steered toward or away from a service for a particular reason without an assessed need justifying it)
4.14. Designated entity should attempt to conduct a preparation meeting with participants before their PCSP meeting. Designated entity should check for participant understanding throughout the PCSP meeting	1. Reference toolkit here/packet/notice (video format too) 2. KCDD, families together, SACK, KDADS, DDOs, etc. 3. Reference guide with the designated advocates for each waiver group 4. Identify times for check-ins (what does that look like?) (before, during, after?) was our pre-meeting helpful? 5. Pre-PCSP questionnaire checklist
Additional comments for the STP:	1. Regarding the assessment process – what is the "universe"? How many providers were given the opportunity to take the attestation survey or how many HCBS providers are there? 2. Can the STP be put into plain language? 3. Can the State make more clear the compliance levels? What do they look like? 4. Can the State clarify what is a statistically valid sample size regarding the number of settings selected for onsite visits (page 5, Onsite Assessment Process, end of paragraph 1). 5. As an MCO, when I'm working through the credentialing process with a provider

	who is requesting heightened scrutiny, what does that look like? 6. There is a need for transparency by the State in what data is being gathered with the assessments.